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“JE MANGE ÉNORMÉMENT.”

THE words given above are those with which, as Captain Young-husband informs us, a Russian, Colonel Sokolowski, in charge of a Siberian outpost, invited him to follow suit at dinner. The meal to which it was a prelude was in keeping with the terms which ushered in the repast. Six bottles of wine and beer were supplied to each guest, and course after course of the most substantial dishes were served up. The Colonel and his companions are described as strong robust men, the masters of several languages, leading a rough life, and bursting with health. Their spare time was spent in smoking, drinking, and playing cards. Their wives were with them.

Respecting the ponies and mules of the same district, the same author records that they were fed enormously. When not at work, they were always eating. The instant they stopped for rest they would be put to a trough, which would be piled up with a feed of barley or millet mixed with bran, or chopped millet-stalks or straw. This, and watering them, would occupy the greater part of the two hours' halt. The result was “that their owners could get the fullest amount of work out of them,” and that two animals would draw twelve hundred pounds of goods for thirty miles a day without difficulty, and that they could stand the cold of the frosty nights without any covering.

The author of “Lothair” described one of his characters, generally supposed to be intended for Cardinal Manning, as replying to his hostess’s pressing remonstrance at his allowing the dishes to pass him, “Thanks, your Grace, I neither eat nor drink.” Nor was there much in the Cardinal’s appearance to belie such a statement, yet he was a man of great mental energy and unwearied industry. He was, perhaps, a good example of what Shakespeare thought of when he wrote “the mind shall fatten while the body pines.” Undoubtedly many men of great energy have been small eaters. A late distinguished physician and an authority on diet, who used to assert that he hardly knew what it was to feel tired, and who never seemed so, regarded himself as a very small eater. He would probably have recorded his habits much in the same terms as did another self-observer, as industrious in his way as either Sir Andrew Clark or Cardinal Manning. William Cobbett appeared to be always ready for work and always clear-headed. Describing his own habits as to diet, he writes :—

“Some poet has said, that that which is given in *charity* gives a blessing on both sides—to the giver as well as the receiver. But I really think that if, *in general*, the food and drink given came out of food and drink *deducted* from the usual quantity swallowed by the giver, the *blessing* would be still greater and much more certain. I can speak for myself at any rate. I hardly ever eat more than *twice* a day; when at home, never; and I never, if I can well avoid it, eat meat any *later than about one or two o’clock in the day*. I drink a little tea, or milk and water, at the usual tea-time (about seven o’clock); I go to bed at eight, if I can. I write or read from about four to eight, and then, hungry as a hunter, I go to breakfast, eating *as small a parcel* of cold meat and bread as I can prevail upon my teeth to be satisfied with. I do just the same at dinner-time. I very rarely taste *garden-stuff* of any sort. If any man can show me that he has done, or can do *more work*, bodily and mentally united—I say nothing about *good health*. for of that *the public* can know nothing—but I refer to *the work*; the public know, they see, what I can do, and what I actually have done, and what I do; and when any one has shown the public that he has done, or can do more, then I will advise my readers, attend to him on the subject of diet and not to me.”

It is to be remembered, however, respecting Cobbett, and perhaps some others who have left us statements as to their personal habits, that he was by no means very exact in what he said. Without any intentional falsehood, such men often record, as if it had been the habit of their lives, that which under special circumstances they have practised for a week or two.

We do not now write for dyspeptics, but for those who enjoy

good appetites and sound digestions. Obviously it is possible for such either to restrain or to indulge their desire for food. There is thus a large class in which, by systematic cultivation, the consumption of food might be much increased. Ought such cultivation to be encouraged, or the reverse? No doubt but that many might maintain health with a much more restricted allowance than they are accustomed to. Would they be the better for such restriction? How about the Weir Mitchell treatment, and that adopted at Nordrach? At the latter place an attendant stands over the patient and compels him to finish what is put before him. Are there many amongst those who account themselves healthy who would become more secure from disease if some sort of compulsion of this kind were enforced upon them as a preventive measure? There are, of course, other expedients short of compulsion which may be brought to bear. Many young persons think it a virtue to restrict the appetite for food. Ought they to be told that, like some other virtues, it has its dangers and risks?

Do any dangers attend the habitual consumption of more food than is absolutely necessary, provided it be of good quality? Is mere excess in itself prejudicial, or does the overplus pass harmlessly away? The answer to these questions must, of course, depend much upon the habits of the individual. If great demands are to be made upon the system, whether physical or mental, then the supply should be liberal. It should also be varied. For anything we know to the contrary it may be very desirable to supply to the tissues the elements of nutrition in varied forms. It may be that different tissues of the body exercise some sort of selection as regards what they make use of for repair of waste. This may be of especial importance in reference to the nervous system. Small quantities of articles of diet, reputed to be only nervine stimulants, may possibly be real nutrients when not injudiciously used. That such an end should be served it is probably essential that they should be supplemented by plenty of ordinary food. Tea and coffee and tobacco hurt no one who eats well, and the same is, with an added caution, true of wine.

ON RECOVERY FROM SYMPTOMS OF TUMOUR OF THE BRAIN.

THE diagnosis of intracranial tumour necessarily carries with it anxieties of the very gravest character. When the growth is syphilitic, much, no doubt, may be accomplished by appropriate medicinal treatment, though even here disappointments are not very infrequent. Again, it is possible to collect from medical literature quite a respectable list of cases in which tumours of the brain have been discovered on *post-mortem* examination though no symptoms of their presence were evident during life. These exceptional cases of tolerance on the part of the brain tissue, however, hardly touch the practical position created by the numerous examples of tumour in which serious symptoms herald only too surely the approach of a fatal issue. Yet there is good reason to believe that in a not inconsiderable number of cases a tumour of the brain ceases to grow, that the symptoms dependent on it subside, and that the patient makes either a complete recovery or, more frequently perhaps, regains his general health with loss of sight due to post-neuritic optic atrophy. Illustrations of the truth of these propositions are usually found in children or young adults, in whom, it may be presumed, the tumours are tubercular in character. Necessarily in these cases the diagnosis stops short of complete verification, and is subject to qualification due to the absence of *post-mortem* demonstration. But the clinical evidence is both abundant and strong. In some instances the patient may complain of nothing more than occasional, perhaps periodic, attacks of more or less severe headache, attended or not with vomiting, and in the intervals may regard himself as in his usual health; though no defect of sight may be experienced, the ophthalmoscope reveals a double optic neuritis; and, still later, vision fails, and the patient becomes completely and permanently blind. In other respects, however, his symptoms subside, and he regains a full measure of general health and vigour. Or occasionally he attains a still more satisfactory recovery, the optic neuritis completely resolving without appreciable injury

to the conducting power of the nerve-fibres. Considered alone these cases may possibly be contested as examples of recovery from tumour of the brain, even though they present in their clinical history the three classical symptoms of headache, vomiting, and double optic neuritis. But they are continued by intervening instances of gradually increasing severity into cases in which the patient has a prolonged and serious illness, marked by numerous and extreme symptoms of obviously cerebral origin, extending often over several months, and yet terminating in restoration to health, the recovery, however, being usually or frequently qualified by permanent loss of sight. These cases are often, in their early stages, diagnosed as meningitis, and their recovery is sometimes quoted in confirmation of the diagnosis, as against the suggestion of tumour. The duration of the symptoms, the occurrence of localised paralyses (which are not infrequently present), and the existence of considerable double papillitis terminating in optic atrophy, are facts difficult to reconcile with a diagnosis of meningitis. On the other hand, these symptoms are exactly paralleled in cases of tumour of the brain terminating fatally, and verified by *post-mortem* examination. And again, in an occasional case, in the group now under consideration, the diagnosis of tumour has been confirmed by the opportunity of examination following the death of the patient at a more or less remote date. One of the most striking instances in this respect is a case recorded by Dr. T. K. Monro. The patient was a man of 63 years, who died of malignant disease of the stomach. For many years he had been an inmate of a blind asylum, and he attributed his loss of sight to a severe illness which occurred when he was 16 years of age, and which confined him to bed for many months. The autopsy revealed a shrivelled myxomatous tumour almost replacing the left half of the cerebellum, and atrophy of the optic commissure and optic nerves. The case thus affords a complete demonstration that a tumour of the brain—in this instance a non-tubercular tumour—which has caused a dangerous illness and double optic neuritis, may pass into a condition of complete quiescence, the patient subsequently enjoying good general health for close on half a century. These circumstances suggest that enquiry and investigation might profitably be pursued among the inmates of asylums and homes for the blind. There are also

numerous cases of double optic atrophy, of more or less obscure origin, to be met with in the out-patient clinics of our ophthalmic hospitals, and the expenditure of some time and trouble in tracing these would probably be well repaid. Many of these patients are in circumstances which compel them, sooner or later, to seek admission either to a workhouse or to some semi-private charitable institution, and here, when death occurs, every effort should be used to obtain a complete examination of the central nervous system. The records of cases of brain tumour in which the symptoms have been in abeyance for many years might in this way be much increased. And apart from the scientific interest of the question, there would be a practical outcome in the shape of a more hopeful prognosis and more courage and perseverance in treatment.

C. O. H.

POTASSIUM OR POTASH? A QUESTION OF NOMENCLATURE.

As accuracy in small matters, as well as in more important ones, is to be desired, we readily welcome the strictures of one of our critics who comments adversely on the use of the term "iodide of potash," in what he describes as the "severe academic atmosphere of the Polyclinic." The phrase in question is, we admit, chemically inaccurate, and ought not to be employed. Possibly some interest, and perhaps a measure of value, may be derived from an examination of the incriminated designation and of titles allied to it. The name potash was first applied to the substance procured by burning wood, washing the ashes with water in a metal or other kind of pot, and decanting and evaporating the solution. The residue so obtained—now known to be an impure form of potassium carbonate—was regarded as an elementary substance, and was, as an indication of its source, named potash, or rather potashes. After the isolation of the metal potassium by Sir Humphrey Davy in 1807, the name potash was applied to the oxide of potassium, and the original potashes were recognised as formed by the union of potash with car-

bonic acid gas, and were known as carbonate of potash (K_2O , CO_2); and a parallel constitution was credited to the sulphate, nitrate, and other salts. They were all regarded as salts of potash. Hence therefore the names *potassæ carbonas*, *potassæ sulphas*, *potassæ nitras*, etc., etc. But obviously this view could not apply to salts having the constitution KCl , KBr , and KI . Here there is no question of potash. On the contrary, there is in each of these compounds the direct union of a halogen element with the metal potassium, and therefore such salts were distinguished as salts of the metal, and were named potassium chloride, potassium bromide, and potassium iodide respectively. The result of this position, applied to the metals generally, was the recognition of two classes of salts, the first consisting of a metallic oxide (*e.g.*, K_2O , CaO) and an anhydride or so-called acid (*e.g.*, CO_2 , SO_3), and the second of a metal in combination with some other element, as chlorine, bromine, or iodine. The first group were named *oxyacid* salts or *oxysalts*, that is, salts of the oxides of the metals. The second group were known as *haloid* salts (from their chemical likeness to sea salt), or salts of the metals. In more recent years this distinction between salts of the metals and salts of their oxides has been abolished, and now all the metallic salts are regarded as salts of the metals. Therefore, to be strictly correct, it is proper to write not only potassium iodide, but also potassium carbonate, potassium sulphate, etc., etc., and to present the rational formulæ for these as K_2CO_3 , K_2SO_4 respectively, instead of, as formerly, K_2O , CO_2 , K_2O , SO_3 , and so on. The change of view just alluded to first took effect, so far as the British Pharmacopœia is concerned, in the edition of 1885. Previous to that date the distinction between haloid salts and oxysalts was regarded as valid, and thus the official inorganic salts appeared with a nomenclature indicative of this distinction. The bromides, chlorides and iodides were written as compounds of potassium, sodium, or other metals in such terms as *Potassii Iodidum*, *Sodii Chloridum*, etc., whilst carbonates, sulphates, nitrates, and others, appeared as salts of the metallic oxides, and were therefore written *Potassæ Carbonas*, *Sodæ Sulphas*, and the rest. But in the Pharmacopœia of 1885, and again in the edition of 1898, the names of all the metallic salts have been written in a fashion implying that they are compounds of the several metals, and thus we have not only *potassii iodidum*,

but also, *e.g.*, potassii carbonas, sodii sulphas, and ammonii acetas, instead of potassæ carbonas, sodæ sulphas, and ammoniæ acetas respectively. In a similar manner the calcium compounds, which were formerly viewed as formed by the union of calx or lime (CaO) with the several acids, and were written calcis carbonas, calcis sulphas, and the rest, now appear as salts of calcium, under such names as calcii carbonas, calcii sulphas, etc.; and so on with the salts of magnesium and other metals. Oxide of calcium (CaO) still appears as *Calx*, and oxide of magnesium (MgO) as *Magnesia*, but the former carbonate of lime is now known officially as carbonate of calcium, and the term sulphate of magnesium is substituted for sulphate of magnesia. Our critic is therefore perfectly right in finding fault with the phrase iodide of potash, for which no defence can possibly be attempted. Indeed, as now appears, his commendable anxiety for accuracy in chemical phraseology might have justified the adoption of a wider censure, though not perhaps on equally sure grounds. To speak of iodide of potash is, we admit, to sin against both reason and history. Carbonate of potash and its congeners are less grave offences, but they cannot advance a plea of justification according to modern theories. They can claim the sanction of a former custom, but their present employment indicates some failure to appreciate one aspect of the fuller chemical doctrine of our later day.

C. O. H.

SYPHILIS AND THE COMMUNION CUP.—Dr. Albert S. Ashmead in *Public Health* has the following paragraph: "It is interesting to mention that it is an historical fact that in the twelfth century children were forbidden the communion on account of the dangers of disease introduced into Europe from the East by returning armies of the Crusaders. Then syphilis was spread to western Europe as much by the communion cup as by the brothel." Can any of our readers give us reference to the sources upon which this statement is based? Were children ever forbidden the communion for fear of contagion, and if so by what authority and where? We want chapter and verse. That the fear of syphilis did not produce such a prohibition in the twelfth century is tolerably certain, since there was no syphilis in Europe at that time. It was leprosy, and not syphilis, which the Crusaders were credited with bringing from the East. It was the return of Columbus's sailors from the West Indies in the end of the fifteenth century which was believed to have introduced syphilis into Europe.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON LATERAL CURVATURE OF THE SPINE.

[*Abstract.*]

BY SIR WILLIAM M. BANKS, LL.D., F.R.C.S.

LATERAL CURVATURE OF THE SPINE is a condition in which muscular weakness is the predominating factor. However greatly in individual instances the spinal column may be deformed, the vicious position is due to alterations in the position and shape of the bones as the result of unequal pressure, and not to inflammatory or destructive changes. In this respect, therefore, the pathology of the disease is quite different from that of angular curvature.

Even in health there is in the lower cervical and upper dorsal region a slight lateral flexion of the vertebral column, the convexity of the curve being towards the right side; and the most frequent pathological curvature is an exaggeration of this normal condition. The existence of this natural, so-called upper dorsal, curvature, is probably associated with the more frequent use and greater muscular development of the right upper limb; with the heavier weight of the viscera on the right side of the vertebral column; and with the situation of the descending aorta to the left of the middle line, the pulsation of the artery on the young and yielding spine tending to force the column over to the right side. Another influence in the same direction is provided by certain of the respiratory muscles. One of these is the serratus magnus. This is attached posteriorly along the ventral aspect of the vertebral border of the scapula, whilst anteriorly it is inserted by separate digitations into the upper eight ribs. When the serratus acts as a muscle of inspiration its posterior attachment must necessarily be fixed, in order that the contraction

of the muscle may produce expansion of the chest. This necessary fixation of the scapula is secured by the action of the rhomboid muscles, which run from the vertebral border of the bone to the lower cervical and upper dorsal spines. The rhomboid muscles thus continue the line of the serratus magnus backwards to the spine. Hence, when the muscle contracts for respiratory purposes, there is a measure of strain on the spinous processes in the dorso-cervical region, and as the right lung is the larger of the two, and the right thoracic movement more active than the left, there is a tendency to drag over the spinal column towards the right side. Whatever be the explanation, it is undoubtedly the fact, that there exists an inherent tendency to a right lateral curve in the upper dorsal region.

The cases of lateral curvature may be divided into two classes, viz.:—(1) those in which the primary curve is in the dorsal region, (2) those in which the primary curve occurs in the lumbar region. In each variety the primary curve is followed by the appearance of a secondary or compensatory curve, in the first instance in the lumbar, in the second in the dorsal region. The cases of primary dorsal curve are, as already intimated, the more frequent. For the most part the convexity is to the right side, being an exaggeration of the normal inclination in this direction. The circumstances which produce a pathological dorsal lateral curvature are (*a*) occupations or exercises which are accompanied by excessive use of the right upper limb; (*b*) carrying a relatively heavy weight repeatedly on the same side—a frequent example is provided by nurse-girls and children who are engaged in carrying infants, and as this is usually done on the left side, the curvature in these instances is usually towards the left; (*c*) contraction of one side of the chest, as after a pleural effusion or empyema with subsequent non-expansion of the lung; (*d*) chronic condensation of the lung leading to defective movement of one side of the chest.

The early diagnosis of a slight dorsal lateral curvature is to be made by stripping the patient to the waist, marking the tips of the spinous processes with a blue pencil, and observing whether the dotted line so defined does or does not deviate from the mesial plane. Even when the spine seems straight, some degree of curvature may exist. Hence the next step is to palpate carefully along

each side of the line of the spinous processes, in order to compare the degree of resistance encountered on the two sides. When a curvature exists there is always rotation of the bodies of the vertebræ round a vertical axis, and the rotation is always towards the convexity of the curve. As a result of this the transverse processes on the convex side of the curve are swung backwards, and hence produce a feeling of resistance on the corresponding side of the middle line. This offers an effective contrast to the condition on the concave side of the curvature, where necessarily the transverse processes are rotated forwards and are thus even further from the surface than in health. It is thus a valuable diagnostic sign. In more advanced cases the rotation of the vertebræ becomes more extreme, and in time the angles of the ribs, being carried backwards with the transverse processes, project posteriorly, and make the scapula on the affected side unduly prominent. It is this "flying" scapula which is oftentimes the first feature that attracts the attention of the patient or her dressmaker. When it exists there is no doubt about the diagnosis. The case is certainly one of lateral curvature in the dorsal region.

Primary lateral curvature in the lumbar region arises in circumstances which depress one end of the transverse axis of the pelvis and raise the other, so that the axis, instead of lying in the horizontal plane, becomes oblique. This may be brought about by a slouching habit of standing, or by sitting in such a position that the weight of the trunk rests only on one buttock, or it may be due to inequality in the length of the lower limbs. Examples of vicious positions in sitting and standing are common among school girls. The weight is rested mainly on one lower limb, with the result that the corresponding end of the transverse axis of the pelvis is raised, and a curvature of the lumbar spine towards the same side is produced. Inequality in the length of the lower limbs may be due to such causes as disease of a knee joint and infantile paralysis. Slight attacks of the latter are apt to be overlooked or forgotten, and in after years very careful measurement may be necessary to detect the resulting shortening. The evidence of lumbar curvature which usually first attracts the patient's attention is prominence of one or other hip. The hip is described as "growing out."

The treatment of lateral curvature is comprised in two general

statements: (1) Remove the exciting cause of the condition; (2) improve the nutrition and tone of the muscles of the back. A faulty position of standing or sitting must be corrected, and the patient drilled to secure an erect carriage. This demands attention both at school and at home. Suitable desks for school children, allowing them to read and write without stooping or adopting a constrained posture, should be provided, and a slouching habit of sitting or standing should be prevented. If one lower limb is shorter than the other, the boot worn on the shortened limb should be supplied with a thick heel and sole to correct the deformity.

In reference to the condition of the muscles, general measures should be taken to strengthen these, and particular efforts should be made to develop those on the side opposite to that towards which the curvature is directed. Bathing and rubbing the muscles of the spine helps towards general and local muscular vigour, whilst the use of the left hand in such games as tennis and hockey will be a correcting influence in cases of right upper dorsal curve. Gymnastic exercises, whilst favourable to health and muscular development generally, do not *per se* directly tend to secure an erect spine and a graceful carriage. That end can only be attained by drill and supervision of posture in early life. Hence in cases of spinal curvature, whilst gymnastic exercises have their value, they will not atone for a bad and slouching habit whilst sitting or standing. In many cases it is well to keep the child from school, and to divide the day between running about in outdoor exercises on the one hand, and rest in the recumbent posture on the other. In such exercises there is no danger of the vicious positions so readily adopted whilst sitting or standing. And when the child is tired, rest on the back in an extended position helps to secure a straight spine. All that is needed for the latter purpose is a flat deal board covered with baize, and having near one end a hole for the reception of the occiput. This may be fitted into a light frame, with an arrangement to secure its inclination at a convenient angle, and is far superior to elaborate and expensive couches, if only for the reason that it can be readily carried about and placed where the patient may get fresh air and sunshine. The fear that lying down will weaken the muscles of the back would be reasonable enough if the adoption of such a posture was pursued as a continuous policy, but is entirely groundless when

rest is alternated with active exercise. Sayre's suspension apparatus is of some value as tending to straighten the spine, and simple elastic straps—each with one end fixed to the wall—form a useful discipline for muscular drill. Cycling may be permitted provided the machine has high handle bars to allow an erect posture, and a saddle at such a height that the pedal movements compel full extension of the limbs.

One other aspect of treatment is the question of mechanical support for the spine. Unfortunately lateral curvature has in some measure obtained in the public mind the dignity of a "speciality." And it is still the custom, in some quarters, to encase the unfortunate patient in "irons," which are screwed up and locked in a particular position by a "specialist," who feels it necessary, for the success of the treatment, to retain possession of the key. This, it will be seen, is in direct opposition to the principles of treatment defined in the earlier paragraphs of this lecture. In exceptional cases, where, in consequence of neglect, the deformity has become extreme, it is no doubt necessary, in order to relieve pain and distress, to support the spine, and this can best be done by a carefully fitted poro-plastic jacket, strengthened if desired by strips of aluminium. But such cases are rare. In the vast majority of instances patients need no mechanical support. They require, on the contrary, free play for the muscles, for it is by improvement in muscular tone and force that the extension of the curve will be checked, and rectification of the position of the spine in a greater or less measure secured.

THE URETHROTOMIES FOR STRICTURE.

[*Abstract.*]

BY REGINALD HARRISON, F.R.C.S.

MR. REGINALD HARRISON lectured on this subject and handed round twelve diagrams relating to it. The latter included illustrations of internal urethrotomy, or section of the contraction from within the urethra; external urethrotomy, as applied for stricture;

and the combination of internal with external urethrotomy, or perineal section. Before referring to these several operations he described the method of dilating strictures with flexible and metal bougies, as he did not wish to be understood as an advocate for treatment by a cutting operation, save in exceptional and definite circumstances. Intermittent and continuous methods of dilatation were then described, and the various forms of bougies shown. Mr. Harrison laid stress on the use of a long conical flexible bougie, generally known by the name of "the whip," as a most important aid in the process of effecting easy dilatation of strictures. Its more general adoption had considerably reduced the number of so-called "impassable strictures." After describing and demonstrating from illustrations the operations of internal and external urethrotomy, he spoke at length of their combination as representing a single operation which has a wide range of usefulness in connection with various kinds of urethral stricture and some of their more serious complications, though, judging from text-books, it was not so well known as it should be. His arguments in favour of this combination were chiefly based on the consideration that though internal urethrotomy was in many instances a successful operation in the case of stricture not adapted for dilatation pure and simple, it was open to objection on two grounds; first, that by reason of the nature of the wound the patient was liable to the risks common to all undrained wounds, that is, there is the probability of rigor and fever, sometimes of a formidable character; and secondly, of the formation of an exceptionally contractile form of scar tissue. These conclusions and comparisons he had arrived at from the study and observation, over a considerable period, of accidental lesions of the urethra caused by injuries. When the latter are treated by open drainage, as by a perineal puncture and the insertion of a drainage tube into the bladder, there is no risk of urinary fever, and the resulting scar tissue is not of that contractile character which usually follows urethral injuries. It is in fact quite in keeping with the cicatricial tissue which follows operation for median and lateral lithotomy. The exceptional nature of urethral scar tissue, and the liability to rigors and fever following injuries of this part, are considerations that have not been studied as sufficiently as their importance demands. It is extremely suggestive to notice the difference the

introduction of a drainage tube into the bladder makes relative to the contingencies attending such injuries. The steps of the combined operations were then illustrated as consisting of an internal urethrotomy by Maisonneuve's instrument, immediately followed by a perineal section or puncture for bladder drainage as described in the previous lecture,¹ to the figures of which reference should be made. The after-treatment was conducted on similar lines. The treatment of what are termed impassable strictures by Wheelhouse's method was then discussed, Mr. Harrison urging that the conclusion as to the impassibility of a stricture should not be too hastily arrived at, the question being an important one, as upon it hinged what attempts should be made to restore the natural passage, structurally occluded. The lecture concluded with the examination of a patient who had been submitted to the combined urethrotomies for a traumatic stricture which had been thought to be impassable, and with remarks on a mode of stretching some strictures by a modification of Holt's dilator, which was shown. Mr. Harrison stated that at his next lecture he would describe and illustrate the following subjects:—The restoration of the imperviously strictured urethra; the treatment of traumatic ruptures of the urethra, with and without fracture of the pelvis, and those caused instrumentally (false routes or passages); and the treatment of extravasation of urine and periurethral abscess arising from stricture of the urethra.

SURGICAL OPERATION FOR BRONCHOCELE.—The surgical operation for bronchocele is described by Celsus. He says that its contents may be evacuated by caustics, but that the knife is a more expeditious process of cure. For this purpose he directs us to make a single incision down to the cyst, and to dissect it from the surrounding parts with the fingers. When its cyst cannot be removed he recommends us to destroy it with caustic medicines.

The poet Juvenal alludes to the prevalence of bronchocele among the people at the foot of the Alps.

Pliny attributes it to the corruption of the water.

Rolandus, Guy of Cauliac, and other of the earlier modern authorities, direct us to remove the tumour by means of two cross setons.—Paulus Ægineta. Commentary by Dr. Francis Adams.

¹ See THE POLYCLINIC, vol. v., p. 233.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY JAMES TAYLOR, M.D., F.R.C.P.

Tuesday, December 3, 1901.

Progressive Muscular Atrophy.

THIS case was one in which the diagnosis was entirely beyond doubt. The patient was a man of 30 years, showing in a high degree atrophy and weakness of the muscles of the hands, upper arms, and shoulders. There were also spontaneous fibrillary twitchings in the affected muscles. Sensation was quite undisturbed, and the history of gradual failure of muscular power in the upper limbs extended over several years. These facts made the recognition of the case as one of progressive muscular atrophy a matter of practical certainty. The special feature of interest was raised by an examination of the tendon-jerks. In the upper limbs these were essentially normal. The knee-jerks were active in the sense that they were, if anything, rather more decided than usual. But no ankle clonus could be obtained, and stimulation of the sole failed to produce any extensor movement of the great toe (Babinski's sign). The importance of these facts is due to the division of the cases of progressive muscular atrophy into two groups. In the first group are cases, such as the present, in which the lesion is a degeneration of the multipolar nerve cells in the anterior cornua of the spinal cord, leading to muscular atrophy and paresis. In the second group the lesion is not confined to the lower—the spino-muscular—segment of the nervous system. It involves also the upper neuron or cerebro-spinal segment. There is, in short, in these cases, sclerosis of the lateral columns as well as degeneration of the cells in the anterior horns, that is, the disease

involves the termination of the cerebro-spinal segment and the commencement of the spino-muscular one. Hence, in addition to muscular atrophy, these patients exhibit the results of lateral sclerosis, such, for example, as more or less spastic rigidity, and heightened tendon phenomena. The cases in which the clinical conditions are those of simple progressive muscular atrophy, indicating pathologically a lesion in the anterior cornua, were described by Charcot as the *protopathic* variety. On the other hand, when in addition to muscular atrophy there are such evidences of lateral sclerosis as more or less rigidity of the limbs, and exaggeration of the tendon-jerks, he spoke of the atrophy as *deuterothatic*, regarding the lesion of the anterior cornua and the consequent muscular wasting as secondary to the sclerosis of the lateral columns. Further, the same physician described the condition in which rigidity and exaggerated tendon-jerks are associated with muscular wasting under the term *amyotrophic lateral sclerosis*. At the present day there are some authorities who maintain that the lesion in all cases of progressive muscular atrophy involves the lateral columns as well as the anterior horn cells; and that in different cases the clinical evidences vary according to the relative extent and order in which these two structures are attacked. If the anterior cornua suffer early and severely, the muscular atrophy will be accompanied by little or no evidence of lateral sclerosis, as the clinical results of such sclerosis will be prevented by the interruption of the nerve path, due to the degeneration of the spinal nerve cells. Should, on the contrary, the main stress of the disease fall on the lateral columns, and the anterior cornua be affected later and to a less extent, the clinical picture will be one in which, together with muscular atrophy, rigidity and exaggerated tendon phenomena are prominent features; the case would then be named as one of amyotrophic lateral sclerosis. And between these two extremes are all possible degrees in the measure of prominence of the evidences of lateral sclerosis. Hence the state of the knee-jerks and other tendon phenomena is a matter of considerable importance in every case of progressive muscular atrophy. The more distinctly these give evidences of exaggeration, the more clear is the demonstration that lateral sclerosis is a large factor in the pathology of the case. The question, moreover, is not merely one of exact diagnosis. For

it is certain that the cases of progressive muscular atrophy in which evidences of lateral sclerosis are conspicuous, have a much worse outlook than those in which such evidences are either slight or altogether absent. The present patient provides an illustration of one side of this truth. His condition is certainly a very unsatisfactory one, but his advance to it has occupied several years. And when under treatment some eighteen months ago, faradism and hypodermic injections of strychnine, though by no means curing the patient, certainly effected decided improvement in his condition. As regards the future the probability, it must be admitted, is that the disease will continue slowly to advance, and there is a definite risk that the nerve centres in the gray matter of the medulla, which are in homologous series with those of the anterior cornua, will become affected, and the patient will suffer from bulbar paralysis and the special dangers thus involved. This in all truth is but a gloomy prospect, and it is redeemed only by the chance, which is occasionally realised, that the disease may, sooner or later, cease to advance. But if the prognosis in progressive muscular atrophy is far from good, that of amyotrophic lateral sclerosis is decidedly bad. The patient with this disease invariably gets steadily worse, and usually dies within two or three years of the onset of the symptoms. It is therefore something to the good to find that in a case of progressive muscular atrophy, as in our present patient, there is little or no clinical evidence of a severe lesion of the lateral columns of the cord.

Referring again to what has been said above regarding the situation and extent of the lesion in various forms of progressive muscular atrophy, it may be noted that these statements establish a clinical relationship between lateral sclerosis, amyotrophic lateral sclerosis, and progressive muscular atrophy. In lateral sclerosis the lesion is in the fibres of the lateral columns of the cord, and the chief clinical evidence is muscular rigidity and exaggerated tendon phenomena. In amyotrophic lateral sclerosis the lesion invades, not only the lateral columns, but the next succeeding portion of the motor pathway, namely, the cells of the anterior cornua, and muscular atrophy is consequently added to the clinical signs of lateral sclerosis. From this, by a series of steps in which the evidences of lateral sclerosis become less and less, we arrive at

cases in which no such evidence exists, and the cases are examples of pure (protopathic) progressive muscular atrophy with, presumably, restriction of the lesion to the cells of the anterior cornua.

Another relationship is that existing between progressive muscular atrophy and bulbar paralysis. The nerve cells in the gray matter of the medulla, the degeneration of which gives rise to the symptoms of bulbar paralysis, belong to the same series as the cells of the anterior cornua, and the two groups discharge analogous functions. Therefore bulbar paralysis and progressive muscular atrophy are pathologically associated, in the sense that they depend on degenerative disease affecting nerve cells of the same order. The only difference is that in one the cells attacked are in the medulla or bulbar part of the cerebro-spinal axis, whilst in the other it is the cells of the spinal part of the axis which suffer. When this view is presented, it cannot provoke surprise to find that progressive muscular atrophy is often complicated by the evidences of bulbar paralysis.

An Early Case of Friedreich's Ataxia.

This was a case of very considerable interest, inasmuch as the diagnosis and prognosis were enormously more serious than the patient or his friends had for a moment suspected. What appeared to them a comparatively slight disability, was found on examination to be the early expression of structural change in the spinal cord, of a form and order offering only the prospect of growing enfeeblement, with, as its usual termination, death from some pulmonary or other intercurrent disorder. The patient was a well-grown and fairly active youth of 17 years. He had been sent to the Queen Square Hospital on account of the shape of his feet and of some measure of discomfort, amounting at times to pain, in walking. Beyond this the lad regarded himself as in perfect health—a view in which his father and other friends entirely concurred. On examining the feet each was seen to have a “stumpy” appearance, to be shortened from before backwards, and to present marked exaggeration of the arch of the instep. In short, the condition was a typical example of the deformity known as “pes cavus” or “hump foot.” That deformity carries with it an extremely strong suggestion of Friedreich's ataxia. Yet, with one exception, examination failed to

detect any further evidence in support of such a diagnosis. There was no nystagmus, even in extreme lateral deviation of the eyeballs; the speech was entirely free from any thick or "slurred" quality; the spine presented no trace of lateral curvature (scoliosis); and there was no ataxia or jerking in the movements of either the upper or the lower limbs—all of which are among the classical features of Friedreich's disease. The knee-jerks, however—and the fact is of great significance—could not be obtained, and this, together with the deformity of the feet, may be held to justify the diagnosis. Absence of the knee-jerk is never to be regarded as a normal condition. The age of the patient practically placed tabes dorsalis out of court; and further, the pupils had normal reactions, and there was no history of anything like lightning pains. The lad had not been the subject of infantile paralysis, nor was there any wasting of the quadriceps extensor, such as might result from that paralysis or from myopathic atrophy involving the thigh muscles, and might affect the production of the knee-jerk. Neither was there any history of sore throat, and therefore practically there was no suspicion of post-diphtheritic paralysis, of which loss of the knee-jerk is sometimes the only evidence. Moreover, none of these conditions would account for the deformity of the feet, whilst Friedreich's ataxia explains both this and the absence of the knee-jerks. That diagnosis, therefore, must be pronounced; and it carries with it the serious prognosis already indicated. It means also that the chance of staying the downward tendency of the case is extremely small. Such measures as will help to maintain the general health must be prescribed, but beyond this, medicine is so far as we know of no avail. The clinical lesson of the case is thus not a practical one in the direction of treatment. But there is the very important demonstration of the fact that symptoms easily regarded as relatively slight and unimportant may be the early exhibition of serious structural nervous disease, and that unless such symptoms are carefully scrutinised very unfortunate mistakes, both in diagnosis and prognosis, may be made.

One other feature of the case demands a word of comment. The family history of the patient is quite free from evidences of nervous disease, and this extends to the members of his own generation. It is true that Friedreich's ataxia is a family disease, in the sense that

usually more than one member of the same generation is attacked by it. But isolated instances at times occur, and this seems to be one of them.

[In connection with this case reference may be made to three instances of Friedreich's ataxia demonstrated at the College by Dr. Guthrie Rankin, and summarised in *THE POLYCLINIC*, vol. iv., p. 185. Also to a case of Pseudo-hypertrophic Paralysis, in which there was little evidence of the disease beyond a sluggish character of the gait and absence of the knee-jerks. The patient was under the care of Dr. Dixon, and the condition was described with comments in our last issue, December, 1901, p. 297.]

MEDICAL CASES.

BY GUTHRIE RANKIN, M.D., M.R.C.P.

Tuesday, December 10, 1901.

A Case of Pernicious Anæmia.

THE diagnosis of pernicious anæmia is apt to be somewhat wanting in precision. The disease does not include any distinctive physical signs, nor is there found among its clinical phenomena any subjective or objective feature which makes its diagnosis a matter of absolute certainty. So much is this the case that the question has been raised whether pernicious anæmia as an independent disease really exists. It has been urged that every severe anæmia includes mal-nutrition of the blood vessels with a necessary tendency to capillary or other hæmorrhages, and that, given persistence of the conditions which cause the anæmia, there will be established a vicious circle in which the anæmia produces hæmorrhages, and these in turn aggravate the anæmia. According to this view, therefore, any severe or protracted anæmia may assume a pernicious aspect. There is, as is well known, a theory of the disease which implies a direct contradiction of the statement just made. In this it is advanced that the various features of pernicious anæmia depend upon destruction of blood corpuscles, and that this is due to a specific poison absorbed from the alimentary canal. The fact remains that, whatever be the etiology of the disease, the clinical recognition of a case of pernicious anæmia requires the association

of several different facts, and the exclusion of various conditions which might alternatively account for these facts. The present patient shows that there are certain cases, whatever be their causation, in which anæmia exists in adults as a primary and severe fact, and without any preceding hæmorrhage or other recognised event to account for the depreciation of the quality of the blood. The patient was a sailor, 28 years of age. He was admitted to the Seamen's Hospital, Greenwich, in September of the present year. He was then extremely pale and had all the symptoms of severe anæmia, including a more or less general anasarca. Physical examination failed to detect any lesion which would account either for the anæmia or the dropsy. There was no albuminuria and no enlargement of the spleen, lymphatic glands, or liver, so that kidney disease, splenic anæmia, leucocythemia, and Hodgkin's disease, were practically excluded. There was no evidence of pulmonary disease, and a systolic murmur heard over the base of the heart was obviously of hæmic origin. The history was one of gradual, recent, general failure of health; at no time had the patient suffered from malaria or indeed from any serious form of illness. The anæmia and œdema, therefore, presented themselves as primary facts, and not as symptoms dependent on visceral disease. A detailed examination of the blood showed that the red corpuscles were reduced to 26 per cent. and the hæmoglobin to 20 per cent. of the normal; various forms of red corpuscles were present, including some of the nucleated variety. It is frequent in cases of pernicious anæmia to find that the quantitative relationships of the corpuscles and the colouring matter are the opposite of those observed here. The reduction of the corpuscles is in excess of the reduction of the hæmoglobin, as if from destruction of the corpuscles some hæmoglobin existed in a free state in the liquor sanguinis. In the present case this was not so. But evidence of destruction of the corpuscles was provided by the urine, which contained excess of urobilin. Two other significant facts were noted. First, ophthalmoscopic examination revealed the presence of numerous retinal hæmorrhages, and, secondly, the patient, during his residence, had at times irregular and unexplained attacks of pyrexia. The age and sex of the patient, the existence of extreme anæmia without visceral disease, the evidence of destruc-

tion of blood corpuscles, the retinal hæmorrhages, and the occasional high temperatures, form a symptom-complex justifying the clinical diagnosis of pernicious anæmia.

The patient as presented at the Polyclinic offered a strong contrast to the above description. He was still somewhat anæmic, but otherwise was free from symptoms, and was about to return to his work. The treatment which had been adopted was as follows:—Cacodylate of sodium, commencing with small doses and gradually increasing until a maximum of 2 grains was reached, had been given three times a day. With a view to disinfect the alimentary canal a carbolic mouth wash was used, and β -naphthol in 5 grain doses was ordered to be taken night and morning. The patient also received raw meat juice and bone marrow, and he was kept at rest in bed. Under the influence of these measures the hæmoglobin gradually increased from 20 to 66 per cent., and the corpuscles from 26 to 64 per cent. In speaking of the treatment Dr. Rankin emphasised the value of cacodylate of sodium, and drew attention to the peculiar garlic-like odour it communicated to the breath. He remarked that he had frequently observed that no improvement resulted until this odour was developed. Regarding the future of the patient it must be admitted that there is a distinct risk of the symptoms recurring. Such a result is only too frequent in cases of pernicious anæmia. The prognosis of the disease is certainly not so bad as was originally believed to be the case—a belief which is suggested by the term “pernicious,” and still more by the phrase “progressive pernicious”; the latter being adopted for the purpose of indicating a steady and unrelenting movement towards a fatal termination. Such cases as the present show that this is too gloomy a presentation of the facts. Treatment, frequently at least, checks the progress of the disease, and succeeds in restoring the patient to active life; and this measure of success may be maintained for a very considerable period, provided good hygienic conditions are established. Even if a relapse occurs it may be met by the therapeutic measures which were successful in the earlier attack. This at least is the history of a certain proportion of cases, and possibly some patients attain to a permanent recovery. In other instances, unfortunately, the disease resists all attempts to stay its progress, and leads more or less rapidly to a fatal termination.

Apart from the successful treatment there was a further feature of interest in Dr. Rankin's patient provided by the fact that the patient, some ten days after admission to hospital, passed a tape-worm. It has been suggested as possible that a tape-worm may, in some way or other, cause pernicious anæmia. Such a view is difficult to reconcile with the frequency of the parasite and the relative infrequency of the disease, and it can hardly claim much support from the present case, inasmuch as the patient had begun to show definite evidence of improvement before he got rid of his "uninvited guest."

Tabes Dorsalis and General Paralysis.

This case may be compared with several instances of tabes dorsalis which have been demonstrated at the Polyclinic during the last few months. Taken together they form a valuable clinical exhibition of the various aspects in which the disease may present itself to the physician. In addition to the well-recognised peculiarities of gait, absence of knee-jerks, lightning pains, etc., there have been instances in which an ocular paralysis was the earliest and predominating note, and others in which visceral disturbances (retention of urine, rectal pain, etc.) formed the entire burden of the patient's complaint. In these cases we had examples of the necessity of recognising that the disease may commence altogether apart from sensory or motor disturbances in the limbs. Dr. Rankin's case carries the position a stage further, and shows how a classical picture of tabes dorsalis may be merely the first stage in the expression of general paralysis of the insane. The patient was a man of 50 years. He presented, when first seen, the motor and sensory phenomena of tabes dorsalis, including an ataxic gait, loss of the knee-jerks, Argyll-Robertson pupils, lightning pains, anæsthesia and delayed sensation in the lower limbs, and depreciation of the muscular sense. Some months later he began to display symptoms that are not within the usual phenomena of tabes dorsalis. Thus he suddenly developed an appreciable loss of power in the upper and lower limbs on the left side, the hemiplegic seizure being only of temporary duration. Subsequently he had an attack of unconsciousness, from which he appeared to recover completely, though

he has since displayed, at times, a distinct degree of emotional excitability. As seen at the Polyclinic, in addition to the symptoms of locomotor ataxia, it was observed that the tongue, on protrusion, exhibited considerable tremor, and that when the patient was made to grin there were sharp spasmodic twitchings of the muscles of the face. The pupils, too, were unequal, and not only failed to respond to light, but did not contract in the effort of accommodation. The history of temporary hemiplegia and unconsciousness (presumably due to cerebral congestion), the depreciation of mental tone as shown by an unduly emotional tendency, the lingual and facial spasm, added to the evidences of tabes dorsalis, must be taken as indicating that the case is one of general paralysis of the insane commencing with tabetic symptoms. It is well known, that both in general paralysis and in tabes dorsalis, absence of the knee-jerks, and inequality of and loss of the light reflex in the pupils, are often early motor phenomena; also that the cerebral degeneration of general paralysis may be accompanied or followed by sclerosis of the posterior columns of the spinal cord. In addition it does occasionally happen that spinal symptoms precede the evidences of general paralysis due to changes in the brain tissue. These symptoms may be of the spastic order, or they may be, as in the case now described, those recognised as the signs of tabes dorsalis.

Progressive Muscular Atrophy.

There were two features of interest in this case. The first was a history of injury. The patient had been admitted to a surgical ward on account of an injury to his wrist. After a time, the small muscles of the hand on the injured side were seen to be wasting, and, when examined by Dr. Rankin, evidences of atrophy were detected in the hand muscles of the opposite side and also in the deltoids and supraspinati. The case thus afforded another example of the development of central nervous disease subsequent to an injury. This question has recently been discussed in our pages (see THE POLYCLINIC, December, 1901, p. 295). The other noteworthy feature was that along with the muscular atrophy affecting the upper limbs there was considerable exaggeration of the

knee-jerks. The bearing of this fact on diagnosis and prognosis is discussed at page 17 of our present issue.

Other cases demonstrated were :—(1) A woman recovering from myxœdema under the administration of tabloids of thyroid gland, and (2) two patients with symptoms of disseminated sclerosis.

MEDICAL CASES.

BY SEYMOUR TAYLOR, M.D., F.R.C.P.

Tuesday, November 17, 1901.

THE patients attending on this date were :—

(1) A man, aged 30 years, with tremor of the head aggravated by the effort to secure fixation, slight intention tremor of the upper limbs, and some ill-defined imperfection of speech. The diagnosis was discussed, and the balance of probability was concluded to be in favour of disseminated sclerosis.

(2) A middle-aged man (sent by Dr. Shaw, of Aylesbury) complaining of persistent epigastric pain unaffected by food. There were no physical evidences of disease in either the chest or abdomen, and the diagnosis could not be carried beyond the suspicion of a possible fibrous adhesion between the stomach and some other viscus or the abdominal wall.

(3) A youth, the subject of mitral stenosis (Dr. O'Brien's case). The physical facts were observed, and it was pointed out that in early life endocarditis not only attacked the curtains of the mitral valve, but that in addition it produced fibrous thickening of the ring surrounding the mitral orifice. As a consequence, the size of the orifice becomes fixed at a comparatively early period of growth, and the resulting mitral stenosis is more serious than the changes caused by endocarditis when this occurs in a heart which has reached its full measure of development.

SURGICAL CASES.

BY W. H. A. JACOBSON, M.Ch.

*Thursday, December 12, 1901.**Syphilis in Married Women.*

THE patient was a woman of 37 years. She complained of what she called "a lump in her right breast." This had given her pain, especially at night, and further, as always happens in such cases, she was fearful of the possibility of cancer. For some months she had been under treatment at an out-patient department, where the tumour seems to have been regarded as a fibro-cystic growth, mainly because it had a soft central part. Examination showed that the tumour was not in the breast, but was just to the outer side of the gland. It was a firm rounded mass, about the size, when first seen, of a small orange, and was deeply situated. It was diagnosed as a gumma, possibly arising from the costal periosteum, but more probably set in the substance of the pectoralis major. The diagnosis had for its support, apart from the characters of the tumour, the fact that the woman gave a history of several miscarriages and of children born dead near to full time. Under treatment, too, the mass had in the course of fourteen days shrunk to a third of its former size. The value of some measure of rest in the treatment of the manifestations of syphilis was pointed out. The patient had been kept in the hospital, and this was advanced as an influence promoting the rapid action of the medicinal measures employed. The medicinal treatment had been the administration of 5 grains each of the iodides of potassium, sodium, and ammonium, thrice daily. Such a combination is to be preferred to the potassium salt given alone. Syphilis in married women is frequently exhibited in an atypical form. There may be, as in the present instance, but a single symptom. It is inadvisable to ask questions which may arouse suspicion in the patient's mind, and this consideration, coupled with the limited manifestation of the disease, may readily lead to a mistake in diagnosis, unless attention is given to such indirect evidence as a history of frequent miscarriages. Such a history shows, as here, how syphilis persists in women. This woman has continued for years to display the influence of syphilis in the shape of repeated

miscarriages, though in her own person she appears to have had no syphilitic symptoms until the development of the gumma in her pectoral muscle. A probable explanation of such cases is that the syphilitic poison produces an "impression" on the ovary, and that the persistence of this "impression" accounts for the habit of miscarriage. The condition is parallel to that seen when a mare, which has been once covered by a zebra, will, in subsequent conceptions following intercourse with a pure bred horse, produce striped foals. As regards the limited personal display of the evidence of syphilis frequently noted in married women it may be conjectured that in these cases the woman has not been directly infected by her husband, but indirectly, through the agency of the foetus.

On December 19 Mr. Jacobson demonstrated a second case illustrating the frequency with which syphilis in married women exhibits itself in a very limited fashion. The patient was 23 years of age. She complained of a painful swelling which was found to occupy the lower third of the posterior aspect of the right upper arm, and was situated below the triceps muscle. It was diagnosed as syphilitic periostitis. The absence of any history of injury, and the position of the swelling, were regarded as sufficient to exclude the possibility of simple, non-specific periostitis.

Tubercular Glands in the Neck.

A young woman from whose neck on both sides tubercular glands had been excised was shown, and some remarks were made on the surgical methods which should be adopted in these cases. The operation should be performed sufficiently early in the case to antedate caseation and the matting of the glands to neighbouring tissues; the incisions should be sufficiently free to give ready access to the affected area, and should be planned so that the resulting scars may be as inconspicuous as possible; in removing the glands the dissection should commence at a point where the tissues are undoubtedly healthy; in patients with high temperatures there is probably a mixed infection, and in such cases primary union can hardly be expected; that antiseptic precautions should be adopted goes without saying; the patient should be closely watched for at least five years after operation, and only at the end of such a period be considered practically safe from recurrence. It was urged

that tubercular gland disease should be treated as though it were malignant, having a time favourable for operation which, once allowed to lapse, will probably never return. The opinion was expressed that a spontaneous cure of tubercular glands is a very rare event, and an adverse criticism was passed on the proposal to remove the internal jugular vein as a preliminary step of the operation for excising such glands from the neck.

The Treatment of Lupus Vulgaris.

The case of a woman of 61 years, who during the greater part of her life had been the subject of lupus vulgaris affecting the face, demonstrated the good result which may be obtained by the use of potassa fusa associated with curetting and linear scarification. The woman had been under observation during many years, and was instructed to return for observation every three or four months. Any renewed outbreak of the disease was thus promptly met by the above methods. The case was presented as an illustration of what can be accomplished in the treatment of lupus by ordinary surgical methods which do not require any specialised apparatus and only make a moderate demand on the patient's time. The patient's face had been extensively involved, but the diseased areas are now everywhere covered by healthy and supple scar tissue. This has been secured without anything like serious disfigurement of the patient's features and general appearance. The result is greatly in advance of what would have followed an attempted excision of the lupus patches. This is a practice not to be recommended in lupus of the face. It invariably destroys some of the muscular bundles on which the play of feature depends, and it produces considerable scars in which "nests" of the disease nearly always are found. If skin grafting is attempted, as it must be when the excised areas are considerable in size, the "grafts" are very apt to slough, as it is difficult to keep them perfectly sterile on a region like the face.

Malignant Disease of the Kidney.

Two cases were related and the kidney removed from each was exhibited. The chief features of clinical interest were:—

(1) The fact that in each instance percussion of the loin on the affected side was so tender as to give rise to the suspicion of

calculus. It is to be noted that this degree of tenderness existed, though in neither case had the tumour become septic.

(2) In one patient, though no evidence of secondary extension could be detected, pain in the testicle of the same side as the diseased kidney was a prominent symptom.

(3) Each patient was between 55 and 60 years of age, and gave a history of hæmaturia extending over a period of twelve months.

SURGICAL CASES.

BY W. H. A. JACOBSON, M.Ch.

Thursday, December 19, 1901.

A Case of Multiple Osteo-arthritis, perhaps commencing as a Gonorrhæal Arthritis.

THE patient, a man of 30 years, complained principally of pain in his feet. There was a moderate amount of thickening of the malleoli and of the other tissues in the neighbourhood of the ankle joints, and, in addition, there was on each side a condition of extreme flat-foot. The hands showed much enlargement of the heads of the metacarpal bones and deflexion of the digits towards the ulnar side; rough grating at the metacarpo-phalangeal joints was obtained on passive movement; and there was considerable prominence of the styloid process of each ulna. Evidence of wasting, both in the small muscles of the hands and in the muscles below the knees, was also present. These facts might be regarded as distinctive of the condition known as osteo-arthritis, were it not that flat-foot can hardly be explained as the result of that process. The sinking of the arch of the foot, which leads to flat-foot, is known to depend frequently on softening of the plantar fascia and ligaments as a result of the action of the gonococcus, and by the same agent various forms of joint disease may be produced. Hence a combination of flat-foot and chronic arthritis, more especially when existing in a young unmarried man, should be viewed with suspicion. And the suspicion is strengthened when, as here, the joint troubles commence in the feet, are attended from the outset with considerable pain, and are associated with marked muscular wasting. The treatment to be advised is cod-liver oil in full doses,

the application of Martin's rubber bandages to the legs, and the use of a walking-stick; passive movements might also be employed, more particularly to the upper limbs.

A Case of Charcot's Joint Disease.

This case illustrated the statement that Charcot's joint disease may be a very chronic process, neither leading to rapid destruction of the joint structures nor imperilling the life of the patient. The affected joint was the left knee, which was enlarged, globular, and "bossy"; the outer condyle of the femur was eroded and the head of the tibia expanded; there was some obvious hollowing out of the bone below the tibial condylar surfaces, the destructive changes being in excess of the formative; and there was an abnormal degree of lateral movement at the joint. The patient was a woman, 66 years of age. In consequence of the condition of her knee she had not been able to walk during the last fourteen years. She had been an inmate of a "home," and had been protected from exposure and cold; and it is to this influence that the relatively satisfactory condition of the knee must be attributed. Of course an operation had never been performed or contemplated. There was a history of several miscarriages, of repeated gastric crises, and of difficulty in the action of the bladder; and the pupils exhibited the Argyll-Robertson phenomenon.

Two Cases of Malignant Disease, in which Operative Interference would be Irrational.

The first of these was a stout woman about 55 years of age. She had a considerable fungating tumour in her right breast, of the existence of which she had been aware for at least eighteen months. It was observed that the woman was dyspnoëic, with a "grunting" character of the respiration, and small moist râles were heard over the base of each lung. These facts were held to contraindicate operation. Even were the tumour one which could be comparatively rapidly removed, a decided tendency to pulmonary engorgement necessarily introduces a serious element of risk into the operation. But when, as in the present instance, the operation must inevitably occupy much time, during which the patient, in spite of every care, would suffer some degree of chill, and would

remain, during the operation and for some hours after, in a recumbent position, it is almost certain that hypostatic congestion, with subsequent cardiac failure, would be followed by a fatal issue in the course of two or three days; this result being all the more likely in the case of a stout flabby woman. Further it has to be remembered that, as the patient allows the existence of a tumour for at least eighteen months, it is practically certain that there are already various secondary deposits, though the amount of fat in the subcutaneous tissue prevents their detection. And again, the fungating character of the growth renders the risk of the operation wound becoming septic, definitely greater. It may be urged against the decision not to operate that risks should be run to save the patient and her friends from the nuisance of a foul-smelling sore, such as will certainly result from ulceration of the tumour. But if the patient will take the necessary trouble the ulcer may be kept free from smell. And the question of operation involves wider interests than those of the individual patient. Every unsuccessful operation becomes known over a more or less extensive circle, and tends to deter sufferers from taking or following surgical advice. The public cannot be expected to discriminate between favourable and unfavourable cases. All that is recognised is that Mrs. A. had cancer of the breast, was operated upon, and died in the course of a day or two. Consequently a certain number of other women, including some in whom operation would almost certainly be successful, will decide against similar treatment. Hence, when the chances are decidedly against success, and when, as here, the patient by her own act in delaying to take advice has incurred at least a measure of responsibility for the consequences of that delay, there is a reasonable claim for the consideration of the interests of other sufferers. The probability is that the operation will shorten the patient's life, and this is a sufficient reason for advising against it. When to this is added the prejudice against surgical measures which such failure will certainly excite in the minds of other women who regard themselves as similarly affected, it may be claimed that the prudent and humane course is to refuse operation, even though the patient may desire it.

The second case was that of a man who suffered from an epithelioma of the tongue. At first sight the case seemed eminently

favourable for operation. The tongue was freely movable, and the tumour was confined to the anterior two-thirds of the organ on the right side. So far as the local condition, therefore, was concerned, the prospects were good. The disease could be completely removed, and a sufficient amount of the tongue be left for purposes of articulation and deglutition. But it was noted that in the respiration there was some degree of stridor. For this, obviously, the condition of the tongue could not account. It must mean obstruction either in the larynx or trachea. Further, there was an enlarged lymphatic gland on the *left* side of the neck. It thus became imperative to extend the sphere of examination, and on passing an œsophageal bougie an obstruction was encountered at the level of the junction of the pharynx and œsophagus, and the bougie on withdrawal was stained with blood. There was therefore no doubt that a second focus of malignant disease existed in a situation which rendered its removal impossible, and that all operative measures must needs be futile.

SURGICAL CASES.

BY W. JOHNSON SMITH, F.R.C.S.

Wednesday, December 11, 1901.

Traumatic Motor Paralysis of the Upper Extremity.

A boy, aged 16, whilst working in a biscuit factory in August last, fainted in consequence of extreme heat, and was caught by the revolving strap of some machinery. He was at once taken to the Seamen's Hospital, Greenwich. On admission he was found to be concussed, and presented two superficial lacerated wounds of the scalp on the right side. On coming to, in the course of a few hours, he stated that he could not move his left arm, which, on examination, was quite limp and useless. The condition observed soon after the date of injury, and persistent, though with added progressive muscular wasting up to the present time, may be thus briefly described:—No anæsthesia in any part of the injured limb; no voluntary movement in the following muscles: deltoid, pectoralis major, latissimus dorsi, biceps, triceps, supinators, extensors of wrist and fingers, supra-spinatus and infra-spinatus. The boy could pronate but not supinate the forearm. The thumb could be flexed

and extended, and all the movements of the small muscles of the hand were good. He could flex and extend the fingers at the interphalangeal joints, but could not extend them at the metacarpophalangeal joints. There were feeble abduction and adduction movements of the fingers. There was a speedy and total loss of faradic excitability of the affected muscles. When presented at the Medical Graduates' College, after an interval of about four months from the date of the injury, there was well-marked atrophy of all the paralysed muscles, and the surface of the forearm and hand was blue and cold. There was no reaction to the faradic current, but still no decided indications of loss of excitability to the galvanic current. There was no paralysis of any other limb, and the knee-jerks were normal.

Dr. Purves Stewart, to whom Mr. Smith is much indebted for the results of his careful examination of this case, had diagnosed the above described condition as due to a lesion of the anterior roots of the fifth, sixth, and seventh cervical nerves.

Chronic Tubercular Lymphadenitis.

The patient, a Norwegian seaman aged 31, presented on the right thigh and groin several large movable growths, which were regarded as instances of chronic and tuberculous lymphadenitis, presenting some unusual features. The growths in the thigh were large, soft, and very movable, and the skin over two of them presented two small and shallow sinuses, from which there was a very scanty discharge of thin pus, but no caseous material. The skin of the upper third of the thigh in front was much scarred by thickened and keloid-like cicatrices, the results of two successive operations for the removal of like swellings performed in a foreign hospital. Each operation, the patient states, was followed by speedy recurrence of the disease and rapid growth of fresh swellings. In the pelvis, on the same side, there was a large growth, which seemed to be harder and much less movable than the growths on the thigh. There were no tumours or abnormal swellings of any kind to be found in other parts of the body. The man, though thin and haggard, presented no definite signs of malignant cachexia. He suffered from slight cough, but no specific bacilli could be found in

the sputum, and the only appreciable indication of lung trouble was a roughened respiratory murmur at the left apex.

Mr. Johnson Smith also showed a case of extensive infiltration of the floor of the mouth by a large and soft secondary growth, following repeated operations for the removal of a myxosarcoma of the mandible.

SURGICAL CASES.

BY E. W. ROUGHTON, F.R.C.S.

Wednesday, November 13, 1901.

(1) A middle-aged man with congenital dislocation of both patellæ. Each patella was at the outer aspect of the corresponding knee-joint, with its articular surface facing inwards. There was no appreciable lameness. The patient could walk and run almost as well as others of his age and general condition.

(2) A case of nigrities or black tongue in a man aged 75. The condition gave rise to no symptoms and had been discovered accidentally.

(3) A boy who had inserted a "locust-seed" into his external auditory meatus. Previous attempts at extraction having produced swelling and laceration of the cutaneous meatus, it was found necessary to make an incision over the mastoid, and to displace the auricle and cutaneous meatus forwards; the foreign body was then easily removed.

(4) A man who a week previously had punctured his radial artery at the wrist. There was a small pulsating swelling at the seat of injury, which might be a traumatic aneurism, or a small effusion of blood over an unusually prominent artery. Should the swelling get larger it would be explored and probably excised.

(5) A case of cancer of the breast in a man aged 62.

(6) A girl with paralysis of the ulnar nerve, due to compression by scar tissue. There had been very rapid return of sensation after division of the cicatricial band.

(7) A man whose median and ulnar nerves had been severed two years previously by falling through a glass roof. Two-and-a-half inches of median nerve, hopelessly involved in scar tissue, had been excised, and the ends united. There was considerable return of power and sensation.

(8) A baby, 4 months old, upon whom abdominal section for acute intussusception had been successfully performed.

DISEASES OF THE EYE.

BY ERNEST CLARKE, M.D., F.R.C.S.

Friday, November 29, 1901.

Iritis and Irido-cyclitis.

A NUMBER of cases were shown to illustrate: (1) the clinical evidences of iritis; (2) the frequent occurrence of iritis as part of a widespread inflammation involving, in addition to the iris, the ciliary body (cyclitis), the posterior part of the uveal tract (choroiditis), the vitreous humour (hyalitis), and possibly even the optic nerve and retina (neuro-retinitis).

A woman of 21 years was presented as an example of uncomplicated iritis. There was more or less injection of the conjunctiva on the affected side, but in addition, a zone of pericorneal vascular injection was present, and the iris, compared with that of the opposite side, had a dull lustreless appearance. It was pointed out that these features distinguished the case from one of conjunctivitis, for which iritis is sometimes mistaken, more especially when, as occasionally happens, the inflammation of the iris is unaccompanied by pain. Further, as atropine had been used, the pupil was seen to be dilated; but the dilatation was irregular, a strand of iris tissue in two or three places being adherent to the anterior capsule of the lens near the centre and thus preventing uniform enlargement of the pupillary orifice. These posterior synechiæ are of course an absolute demonstration of the existence of iritis. In a second case, in which atropine had produced uniform and complete dilatation of the pupil (no posterior synechiæ), there still existed manifest proof of iritis in the shape of a ring of pigment dots surrounding the central point of the anterior capsule of the lens. This condition showed that the circumference of the pupil had commenced to become adherent to the lens capsule, and though atropine had overcome the recently formed adhesions, these, in giving way, had left evidence of their existence in the shape of deposits of the uveal pigmented epithelium which covers the posterior surface of the iris.

It was pointed out that the ring of pigment formed in this way is always one of small diameter, as the inflammation, by irritating the oculo-motor nerve endings, contracts the pupil, and thus brings its margin near to the centre of the lens capsule. In a third patient this tendency to produce a circular ring of adhesions involving the whole circumference of the pupil (seclusion of the pupil) was exhibited in the shape of a small immobile pupil which did not yield to atropine, and which was the result of an untreated attack of iritis some three years ago. This case emphasised the importance of bringing every patient with iritis promptly and thoroughly under the influence of atropine, which, not only puts the eye at rest by paralysing the ciliary muscle, but, by dilating the pupil, removes the mass of the iris to the periphery, where it is more distant from, and therefore less likely to become adherent to, the capsule of the lens. If this is not done there may happen either closure of the aperture of the pupil (occlusion of the pupil) by exudation with consequent loss of vision, or what is seen in the present case, viz., seclusion of the pupil. And though this latter may not directly and at first interfere with central vision, it may have very serious consequences, for it necessarily prevents the passage of fluid from the posterior chamber through the pupil into the anterior chamber. Fluid therefore accumulates behind and pushes forward the peripheral non-adherent portion of the iris (*iris bombé*), and sooner or later the intraocular tension becomes seriously raised, and secondary glaucoma may result. The free and prompt instillation of atropine, with the application of leeches or blisters to the temple, and the administration of mercury or sodium salicylate respectively if the patient is the subject of syphilis or rheumatism, comprises the treatment of iritis, and promptly and perseveringly pursued may completely prevent the serious possibilities just described.

It was pointed out that the old method of classifying iritis into serous, plastic and purulent, was totally wrong and unscientific, that the etiology of the disease was the natural means of classification, and that this had the additional advantage of indicating the line of treatment.

The complications of iritis, or rather the conditions which show that iritis may be merely one feature of an extensive inflammation, were exhibited in three patients. In one, a recent case, examination

with a lens detected a number of white fatty-like spots on the inferior half of the posterior surface of the cornea. These spots are deposits of lymph, and it was pointed out that when they are small in size, as in this case, they are deposited generally in the form of a cone, while when the deposits are larger they are usually seen scattered all over the posterior surface of the cornea. This was illustrated by a second patient. This condition used to be called *keratitis punctata*, but it has no connection whatever with inflammations of the cornea. Its chief significance is that the inflammatory process involves the ciliary body, and that the case is therefore one of cyclitis.¹

In a second patient, the extension of the inflammation to the posterior part of the uveal tract was shown by the presence of opacities in the vitreous, and by a white film covering the posterior capsule of the lens, the vision being reduced to the ability to count fingers at a distance of 1 metre. The state of the media rendered it impossible to examine the fundus with the ophthalmoscope, but the condition of the vitreous was sufficient to show that, in addition to the iris and ciliary body, the inflammation had involved the choroid and doubtless also the retina. The patient had thus no prospect of regaining useful vision, as an optical iridectomy, even if it were undertaken, could neither remove the opacities from the refractive media nor restore the structurally damaged retina. Had the patient in the early stage of the disease been energetically treated with atropine, fomentations, leeches, and suitable constitutional measures, this disastrous result might possibly have been avoided. At the worst she would have had a dilated pupil instead of, as now, one contracted and adherent round the whole of its circumference, and would thus have avoided certain risks that have already been discussed. And it is certain that in many cases early and vigorous treatment prevents the extension of the inflammation and preserves the eye for effective vision.

Herpes and Ocular Paralysis.

This patient, a middle-aged man, presented himself with his left eye closed. He could, however, open the eye, but said that

¹ The position of the deposit on the posterior corneal surface was effectively demonstrated by contrasting the case with one of interstitial keratitis producing opacities near the anterior plane of the cornea.

when he did so he suffered from "seeing double and giddiness." For these symptoms there was a sufficient explanation in the shape of a paralysis of the left external rectus. Further examination showed that there was a measure of defect in all the movements of the left eyeball. The patient's history gave a recent attack of herpes frontalis, the scars of which were visible on the left half of the forehead, and he had also suffered from herpes zoster. There was no history or evidence of syphilis. Mr. Ernest Clarke suggested that the condition of the ocular muscles was due to a peripheral neuritis attacking the motor nerves, and was thus allied to the attacks of herpes in which of course peripheral sensory nerves are attacked. The prognosis was therefore regarded as good. For treatment, potassium iodide was prescribed, and electricity was ordered to be applied to the external rectus with a view to maintain the tone of the muscle until the conducting power of the nerve should be restored. The galvanic current with slow interruptions was selected, the positive pole to be placed on the nape of the neck and the negative pole over the insertion of the muscle. To secure painless application of the latter, cocaine is used. The patient, too, is directed to look towards the side opposite to the one affected, so as to bring as large a part of the external rectus as possible into contact with the electrode.

Other patients included :—(1) A case of xerosis of the conjunctiva; (2) a case of lachrymal stenosis; (3) an example of calcareous film of the cornea in a blind eye; (4) leucoma of the cornea treated by tattooing; (5) a child with an exostosis growing from the inner wall of the orbit; and (6) a patient with an ulcer of the upper lid in which the differential diagnosis between syphilis and rodent ulcer had been discussed, and which had promptly commenced to heal under the application of black wash and the internal administration of mercury.

DISEASES OF THE EYE.

BY NORMAN M. MACLEHOSE, M.B.

Friday, December 20, 1901.

Non-senile Forms of Cataract.

FOUR patients, each with opacity of the lens, were shown with a view to illustrate some varieties of the non-senile forms of cataract.

(1) A youth, aged 16 years, exhibited the *congenital lamellar* variety of cataract. It was explained that this condition is due to a developmental error in the formation of the lens. Normally, of course, the various layers of the lens, as they are successively developed, are perfectly clear and transparent. But occasionally, after the formation of a small central clear nucleus, a number of more or less opaque layers are formed, probably in consequence of some nutritive defect; and still later, the peripheral portion of the lens is completed by the production of healthy transparent lens fibres. Hence there results a lens in which a clear peripheral area surrounds a greyish opaque disc. The opacity is more dense at its circumference than at its centre, because, as already explained, the nucleus of the lens is clear, and this distinguishes lamellar cataract from the less common *central congenital* variety, and from any other central lens opacity. It has further to be observed that both eyes are almost invariably affected, that the condition is either congenital or originates in early infancy, and that there is in many cases a history of convulsions, and evidences of rickets; frequently too, as in the present patient, there is defective development of the enamel of the teeth. The treatment will vary according to the amount of vision possessed by the patient. If this is fairly good, and allows the patient to follow his occupation, it is best to do nothing, as lamellar cataract rarely tends either to become more dense or more extensive. On the other hand, if the density of the cataract is so great as to seriously prejudice vision, and there is reason to believe that the fundus of the eye is healthy, one of two courses may be adopted. The one is the performance of an optical iridectomy, that is the removal of a wedge-shaped piece of the iris downwards and inwards from the pupil, so as to allow light to traverse the transparent peripheral part of the lens, and in this way to reach the retina. The other course is to needle the lens. As a result, the capsule being opened, the aqueous humour enters and causes softening and swelling of the lens substance, which gradually becomes absorbed. The cataract is thus got rid of, and a clear path opened for light to reach the yellow spot. The disadvantages of this proceeding are that, as the lens is destroyed, the patient is compelled to wear spectacles for distant vision, and has no power of accommodation, thus needing an extra convex glass for near objects. In connection with

both these operative measures it must be remembered, as bearing on the prospect held out to the patient, that not infrequently in patients who have lamellar cataract, central vision is somewhat deficient in acuteness.

The second patient had an opaque lens the result of needling. He might thus be described as the subject of *surgical traumatic cataract*. The lens had become opaque and was gradually undergoing absorption. The operation had been undertaken in consequence of the existence of a very high degree of myopia. As in this condition the antero-posterior diameter of the eyeball is unduly long, rays of light are brought to a focus some distance in front of the retina. The removal of the lens necessarily lessens the refractive power of the eyeball, and therefore the focus is thrown further back—near to, or actually on the retina. The operation is not free from risk, as, for example, of subsequent detachment of the retina and consequent practical loss of the eye. But when, as here, the myopia is so excessive (—25·0 D. or more) as to prevent a healthy young adult earning his livelihood, it may be undertaken, and the result in suitable cases is often very good.

In the third patient the cataract was *secondary* to a detachment of the retina. As a result of this latter condition nutritive disturbances are produced, and these may lead, as in the present patient, to opacity of the crystalline lens. The case had been under observation from an early stage, and therefore the cause of the cataract was known. When shown at the Polyclinic, however, the state of the lens rendered it impossible to learn the condition of the fundus. Thus if seen for the first time at this stage, the condition might possibly have been regarded as one capable of being improved by extraction of the lens. Mr. MacLehose therefore described the methods by which, in any case of cataract, the physiological activity of the retina may be tested, and emphasised the importance of applying these before entertaining any question of operation. Neglect to do so might lead to the removal of an opaque lens only to expose a structurally damaged and functionally incapable retina. Taking senile cataract as a type he discussed the following tests: First, the pupil light reaction, which ought to show normal activity. Secondly, the *projection for light* ought to be satisfactory. To determine this the patient

is seated in a dark room, and, the other eye being covered, he is made to look "straight to his front." Then, from a feeble light placed to one or other side and behind him, a beam is reflected by means of a plane mirror into the eye to be tested. The light is thrown successively from various points, say from above, below, right and left sides, and in this way, the patient looking straight ahead, the various parts of the peripheral portion of the retina are tested. If the patient is able in each instance to indicate correctly the direction from which the light proceeds, he is said to have "good projection for light," and the peripheral parts of the retina may be presumed to be healthy. A third test is necessary to appreciate the condition of the macular region where, at least in elderly patients, a small patch of choroido-retinal degeneration is sometimes present. To detect this the surgeon holds in each hand a lighted match at a distance of 3 to 6 feet from the patient's eye, and gradually approaches the matches to one another. The test is applied in the dark room, and the two lights ought to be recognised as distinct until either they come into actual contact, or the distance separating them is not greater than 2 to 3 inches. If all these tests are satisfactory it may safely be presumed that the retina is healthy, and that removal of the opaque lens will give the patient, when fitted with appropriate spectacles, a satisfactory measure of vision. Applied to the present patient the tests were anything but satisfactory. The pupil was widely dilated and did not respond to light, and projection for light was both limited and incorrect. Hence, apart from the history, the case was seen to be quite unsuitable for operation. Another feature of the case was that the iris at the circumference of the pupil showed a dark pigmented ring which, by the aid of a lens, could be seen to lie in a plane in front of the anterior surface of the iris. This was explained as the result of undue growth and a partial eversion of the posterior uveal pigmented layer of the iris, which, becoming folded forwards presents itself on the anterior surface. The condition is sometimes termed *ectropium uveæ*. It suggests the development of glaucomatous changes, and in the present case was associated with a definite increase of tension. There were thus abundant reasons for not operating. All that could be done was to leave the eye alone unless it became painful, and then the question of its removal would have to be entertained.

The fourth case was an instance of cataract following injury of the eyeball. The risk of sympathetic ophthalmitis was explained, and the circumstances which would call for the removal of the eye were discussed.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

Loose Cartilage in the Knee in connection with Rheumatic Gout—Recurring attacks of Synovitis.

A MAN, aged 28, engaged in the Church Home Mission, was brought by Dr. Sequeira on account of chronic synovitis after the removal of a loose cartilage from his knee. The operation had been performed by Mr. D'Arcy Power in St. Bartholomew's Hospital in May of the present year, and the patient believed that a piece of bone had been removed.¹ There was a florid scar several inches long on the inner side of the joint. The man still kept at his vocation, which involved much walking, kneeling, &c., but he was lame, and exercise made the joint painful. There was considerable

¹ Mr. D'Arcy Power was kind enough, in response to an enquiry, to supply me with the following particulars as to his operation:—

“November 16, 1901.

“Dear Mr. Hutchinson,—An examination of the notes reveals the following facts about ‘Captain’ C. He was admitted into Harley Ward at St. Bartholomew's Hospital on April 23, 1901, apparently suffering from a loose body in his left knee-joint. About three years ago he was suddenly seized with such a severe pain in his left knee whilst he was standing, that he had to sit down. He has had repeated attacks of a similar kind since the first one, and his knee has swelled up and inflamed after each attack, but there has never been any locking of the joint.”

“It was noticed on admission that the left knee was swollen on the inner side and was tender. The joint contained fluid, and some grating could be felt on the inner side when the joint was moved. I cut down upon the tender spot on May 2, and found that the internal semilunar cartilage was so loose that it could readily be pulled forward out of the wound. I therefore cut it away, flushed out the joint with boracic solution, sutured the capsule of the joint, and closed the wound. The wound healed so well that the sutures were removed four days later, and the knee was gently flexed. The patient was discharged with perfect movement of the joint on May 15. I saw him a few weeks later, when he was suffering from synovitis, which I attributed to his having returned to his avocation too soon.

“There was no question as to the cartilage being loose, for an aneurysm needle raised it easily in its whole circumference.

“I am, yours very sincerely,

“D'ARCY POWER.”

effusion into the joint, and free fluctuation at the usual positions. The movements of the joint were free but attended by some creaking.

We carefully questioned the man as to his family history, and as to the attacks of synovitis from which he had suffered. He told us that his mother was, to some extent, crippled by rheumatic gout, that the disease had also occurred in a grandfather, and that one of his sisters had suffered from rheumatic fever. He himself had been threatened with rheumatism in his knuckles. His first attack in the knee occurred in November, 1898, when, without any sort of sprain, he was suddenly seized with pain in the knee which became much swollen, and he was in bed three days. Between that date and the time of the operation he had twenty such attacks, and they always appeared to come on spontaneously and without any twist or sprain. He had never been seized with sudden pain whilst walking. Since the operation he has had five attacks, but they had been less sudden in onset, and in each the pain usually increased gradually for twenty-four hours before compelling him to lie up. After a few days' rest he was always able to get about again. He has recently had pain in the other knee at times.

I remarked that the history supported the diagnosis of rheumatic gout, which was well-known to be a common antecedent of loose cartilages. Often numerous cartilages, more or less loosely attached, were present, and thus the removal of one was not followed by complete success. It was significant that the man assured us that never on any single occasion had he been able to assign a false step or twist as a cause of his attacks. They had been spontaneous, repeatedly recurrent, and somewhat severe. Such a history implied some association with true gout. Our patient was a total abstainer himself, but he said that his father and grandfather, who were sawyers, had drunk beer freely. His mother was crippled, and no doubt in him the diathesis was inherited. I advised him great care in diet, to continue his abstinence from alcoholic beverages, to abstain from fruit, to take plenty of weak tea, of table salt, and of green vegetables of all sorts; of meat, mutton chiefly, avoiding all bird flesh; plenty also of white fish, and by way of tonics quinine and nux vomica habitually. For local treatment the salt-pack every night in the intervals of the attacks, and the capsicum-pack when there is pain.

The Salt Pack in the Treatment of Rheumatic Gout.

The patient, who was the subject of the above case, presented on a second attendance, three weeks later (November 21st), a very instructive instance of the efficacy of the salt pack treatment. On the former occasion the joint had been full of fluid and was painful, and had almost disabled the man from walking. Now it showed its natural contour without a trace of fluid, and was quite free from irritation. He had followed the plan of treatment above indicated but there could be no doubt that the chief agent in the cure had been the use every night of the salt pack. This pack consists of flannel soaked in a saturated brine of common salt which is wrapped round the affected joint, covered with oiled silk and a bandage, and kept on the whole night. It should be applied every night until the cure is effected. I know of no one remedy which is so almost universally effectual in getting rid of irritation and synovial effusion in connection with rheumatic gout.

Warts. Papillomatosis and its Relation to Lichen Planus, Verrucosus, and "Papillary Psoriasis."

A Jew, about 24 years of age, showed us one hand upon which he had numerous large warts. They were fimbriated, and presented excrescences almost as hard as horn.

He had none on the other hand, and at first he denied that he had any elsewhere. It did not appear that there was anything in his occupation, which he described briefly as that of "selling," which could have specially caused irritation to the hand. He had been sent to us on account of the unusual size and number of the warts. After a little consideration he remembered that he had some on his legs as well, and on examination of these we found unusual and very interesting conditions. His legs, both back and front, were covered with warts in various conditions. Some were round-topped, some nearly flat, and some fimbriated. All were exceedingly hard, and felt like little horns. He admitted that his legs were very irritable, and that he was in the habit of scratching them very much.

I adverted to the fact that it is not usual to see well

characterised warts on the legs, or, in fact, on any other parts than the scalp, face, and hands.

We must, however, accustom ourselves somewhat to the use of abstract terms, and in this connection the term Papillomatosis may be very conveniently employed. We must allow it to denote a tendency to papillary hypertrophy on the part of the individual in whom it exists, which may be brought into activity under a variety of exciting causes, and may produce local results, within certain limits, of considerable variety. Sometimes the overgrown papillæ may be capped by thickened epidermic scales, and a rounded or bee-hive-shaped hard papule is the result. In other cases the tendency to overgrowth may be but feeble, and a low, flat-topped, dry papule is the only result. In some cases the hypertrophied papillæ may remain discrete, whilst in others they may become confluent, and produce a large thickened and rough patch. We have long been familiar with this latter condition, especially on the legs, where it is productive of much irritation, and is probably aggravated and perpetuated by the scratching which it induces.

To this condition the term "Papillary Psoriasis" has been given, but perhaps, after all, it has nothing to do with psoriasis, or, at any rate, only in certain cases. Understanding that Papillomatosis involves the recognition of a personal proclivity, we shall easily understand that it may complicate various forms of dermatitis. Thus psoriasis may be papillary, and so may pemphigus, lichen planus, and lupus. You will find adjectives in reference to all these maladies which imply the observation of this fact. A tendency to papillomatosis is also the basis of many forms of malignant disease. It has long been recognised that a remarkable proneness to common warts is often observed in the relatives of those who suffer from cancer.

The patient whose case we are considering is, then, the subject of papillomatosis, and it has shown itself, as it often does, by the production of different forms of lesion in connection with different kinds of irritation. On his legs, I have no doubt, that it is scratching which has caused the warts, but had he not been the subject of this proclivity he might have gone on scratching for years without any such result. He might have produced excoriations or eczema, but he would not have produced warts. It is not unlikely that he will in

the course of a few years show the coalesced patches to which I have alluded as "papillary psoriasis."¹

It is quite possible that all forms of papillary hypertrophy, although originating in constitutional predisposition, and only excited by local irritation, may have a tendency to self-aggravation, and may become infective. Probably all forms of hypertrophic growth, especially if attended by the phenomena which we know as chronic inflammation, are attended by the production of cell-elements which may prove infective. It is the popular creed that warts breed warts. Hence it becomes very important to destroy them. You may touch them with nitric acid, with creosote, with undiluted liquor arsenicalis, or with pure carbolic acid. All these are efficacious, and will be effectual if persevered with. In severe cases, like that of our patient, in whom the warts are very large and very hard, much the most efficient plan would be the application of the point of a Paquelin's cautery.

Enlarged Lymphatic Glands (? Lymphadenoma).

One of the cases, of which a photograph was taken, was that of a man named Godfrey, aged 30. He had a gland tumour in the upper part of Scarpa's triangle, on the right side. It consisted chiefly of two glands, which adhered, one as large as an egg, the other as a cherry. They were very hard, and not in the least inflamed. Just within the brim of the pelvis another gland-mass, equally hard and painless, could be easily felt. We were told they had been first noticed about four months ago. Nothing whatever could be found on the foot or leg. Some small hard glands

¹ I do not possess any good portrait of this condition from one of my own patients, having lost an excellent one which was taken many years ago from the leg of a medical student. I have, however, seen many cases. The only portrait with which I am acquainted is that figured in Radcliffe Crocker's Atlas under the designation of "*Lichen planus verrucosus of the leg.*" Its subject was, we are told, a man, aged 43, who applied to the hospital for some other ailment. The eruption on his leg had existed for seven years, but, excepting itching, caused him no annoyance. He had no patches elsewhere. It may perhaps be doubted whether a papillary form of dermatitis, which remains for seven years restricted to the legs, is in any close alliance with lichen planus. At any rate, these cases which are all much alike, should take rank as a very definite variety of that malady. It is to be admitted that, in certain cases of generalised lichen planus, papillary patches, not dissimilar from those under discussion, are seen on the legs.

were present in the opposite groin, and one, the size of a small cherry, could be detected in the right arm-pit. There was no history of family tuberculosis or cancer. I remarked that from the position and condition of the glands I had quite expected to find some primary growth, melanotic or other, on the skin of the foot or leg. In this, however, we had failed, and the next hypothesis was that the case might be one of lymphadenoma, commencing in an unusual position. This suggestion derived some little support from the fact that there were some hardened glands in several different regions; but this evidence was but slight in amount. The patient did not admit any failure in health, but he was thin and pale.

I advised excision of the gland mass and the use of arsenic.

COMMITTEE ON YAWS.

THE TERTIARY LESIONS OF YAWS.

WE append here some illustrations of one of the tertiary lesions of Yaws which appears to occur in all countries in which the malady is recognised. The first is one which was sent to us a year ago by Dr. Corney, of Fiji, with the following statement:—

“I venture to think that the photograph of a case of frambœsial polydactylitis (which I enclose for your acceptance) occurring in an adult male Fijian aboriginal, many years after he had had primary and secondary Yaws, may not be unwelcome, and may serve a useful purpose in supplementing an interesting discussion.

“This man was about 37-40 years of age when he first came under treatment, and the fingers and hand had then been affected some six or seven years, according to his own statement. He had had Yaws in early childhood, but could give no useful account of his symptoms then. When he came to hospital the only rational treatment for the condition displayed in the photograph was, obviously, amputation through the forearm, to which he consented. The stump healed without *contretemps*.”

When the photograph was shown to the Yaws Committee, doubts were expressed whether the condition illustrated was one of polydactylitis, and not rather of œdema from a contracted cicatrix.

A question on this point having been submitted to Dr. Corney, the following reply was elicited :—

“The condition displayed in the photograph began, according to the man’s history, seven years before he came to the Hospital. He



*Deep Serpiginous Ulcerations as a Tertiary Symptom in “Yaws,” and Dactylitis.
(From a photograph by Dr. Corney.)*

was a man of about 38 years of age, and had gone through the usual attack of Yaws when a boy of about six.

“The condition was chronic. There had been and still existed to some extent a chronic serpiginous ulceration about the wrist.

This had, in cicatrising, so contracted the integument that it was obvious that a certain amount of œdema of the hand and fingers had resulted from the obstruction to the circulation. But the phalangeal joints chiefly affected showed evidence of chronic sub-acute periostitis. The bones were very soft and spongy."

At the meeting of the Committee at which Dr. Corney's photograph was shown, Dr. Patrick Manson expressed the opinion that somewhat similar conditions were not very infrequent in the African races in connection either with syphilis or some other cause. He subsequently sent us a photograph, of which the



Deep Serpiginous Ulceration as a Tertiary Symptom in a Negro. Both limbs are affected. (From a photograph given by Dr. Manson.)

appended illustration is a copy. On the same photograph, but not in a condition to admit of reproduction, is the representation of a boy whose limbs are covered with large scars and deep ulcerations of a similar kind. No detailed history of either of these patients is in Dr. Manson's possession, but he offers the portraits as showing conditions not uncommonly seen amongst the natives of the West Coast of Africa, and resulting from deep phagedenic ulcerations.

A glance at the man's nose will probably, to many of our readers, suffice for the diagnosis.

Our third illustration of this condition is taken from Sir William Kynsey's atlas of drawings now in the Polyclinic Museum. It was originally supposed to show a sequel of Parangi (the Yaws of Ceylon), but in the absence of history of the patient, Sir William is now inclined to consider the disease a tubercular manifestation. It is tolerably obvious that the three belong to one and the same malady, and they may be allowed to prove that in Fiji, West Africa, and Ceylon, the natives are liable to serpiginous ulcerations, with much destruction of cellular tissue, and resulting in large and deep scars. Dr. Corney's case narrative further proves that these are sometimes the sequela of what is there called "Thoko" or



*Scars resulting from Deep Ulcerations in the Arm of a Native of Ceylon. Dactylitis.
(From a portrait given by Sir W. Kynsey.)*

"Yaws," and the nose in Dr. Manson's portrait supplies a clue as to the real nature of the malady.

DISCUSSION ON YAWS. (*A Correction.*)

Dr. J. M. H. MacLeod writes to correct the statement made on page 313 of our last issue regarding his views on the subject of Yaws. In dealing with the question of a specific bacillus, Dr. MacLeod points out that his investigations were purely histological, and were conducted not on recent but on preserved specimens. Thus in stating that he had not observed any specific bacilli in the tissues he wished merely to record the negative fact, and neither in one direction nor the other did he offer an opinion concerning the

bacteriology of the disease. [We regret that our brief summary failed to do justice to Dr. MacLeod's views, and we gladly insert his correction.]

REVIEWS AND NOTICES OF BOOKS.

THE MOUNTAINS OF THE MOON is the title given by Mr. J. E. S. Moore, a Fellow of the Royal Geographical Society, to an account of his travels in Central Africa in connection with the Tanganyika Expedition of 1899 and 1900. It is well illustrated and has many maps. The author writes well but in a somewhat flippant style, and as his title may imply he aims too much at effect and takes less care as to the detailed record of facts than might have been desirable. We extract the following items as of interest to medical readers and students of Climatology.

Of the Chindé river, near the Zambesi (p. 18) :—

"Night on the river at this time of the year is deliciously cool, even chilly at times, and it is almost impossible to realise that the scene is in one of the most pestilential districts of the whole world."

Of Blantyre, 3,000 feet above sea level, we are told :—

"The air feels deliciously cool after the heat of the river. The place is, however, detestable. . . . The great height of the country makes the climate cool and even cold, but for all that fever is very prevalent. It attacks everyone in the place. It even assailed the members of the Malarial Commission in their own quarters on a little hill."

"As we approach Tanganyika itself the plateau attains the altitude of about 6,000 feet" (p. 71).

Near Lake Pamalombi :—

"This part of the river abounds with fishes and also with fishermen. There are a variety of carp and characinids. . . . The natives use nothing but immensely long, seine-like nets, which they drag across the stream catching sack-loads of fish."

Of the island of Shirwa :—

"The natives are a poor-looking set, more like the gargoyles on Notre Dame than anything else. . . . An old man led us panting and perspiring up the steep rocks, which were 500 or 600 feet in height, and all the way the ground stank of fish and other things unspeakable."

After leaving the Lake the explorers ascended the mountains.

"After leaving Tanganyika we ascended once more and came into the curious Kivaland, high and cool, and charming as a work of art, but of the health of which no tale has yet been told except the authenticated death of a German sergeant, who had lived up there, 5,000 feet in the air, for more than a year before he departed, seized with the blackwater fever, the worst type of African fever that there is" (p. 337).

Of the districts between Nyassa and Tanganyika (Northern Rhodesia):—

“It is a more or less beautiful but an extremely undesirable place. It has however a high æsthetic value, and it will serve in the future in all probability for a few sportsmen and a new school of painters, neither of which care much about discomforts or the probability of an early decease” (p. 72).

The Nyassa and Tanganyika lake districts:—

“We came to Lake Nyassa where almost everyone was dead that I had met there on my former expedition. . . . Again we descended into the valley of Tanganyika itself. On the shores of the lake people have died, are dying and will die; they go on, or rather they go off, there actually faster than they do in the Nyassa region. The English lament their comrades, who, as they say, are planted all about the place, the Belgians do the same, and the Germans follow suit.”

CORRESPONDENCE AND ANSWERS.

POPULAR CURES FOR CANCER.—*A propos* of a recent agitation in the public press, a correspondent sends us some quotations from the twenty-sixth edition of John Wesley's “Primitive Physic,” which was published in 1807. The following may be of interest:—“A bleeding cancer was cured by drinking twice a day a quarter of a pint of the juice of Clivers or Goose-grass, and covering the wound with the bruised leaves. . . . A cancer under the eye was cured by drinking a quart of tar water daily, washing the sore with it, and then applying a plaister of tar and mutton-suet melted together; it was well in two months, though of twenty years' standing.” Other “cures” advised are: “Take Horse-spurs (these are a kind of warts that grow on the inside of the horse's forelegs) and dry them by the fire until they will beat to powder. Sift and infuse two drachms in two quarts of ale, drink half a pint every six hours, new-milk warm. It has cured many. . . . Or, apply Goose-dung and Celandine, beat well together, and spread on a fine rag. It will both cleanse and heal the sores. Or a poultice of wild parsnip, flowers, leaves, and stalks, changing it morning and evening, or scraped carrots.” So far as we know, only one of the numerous remedies in Wesley's catalogue is heard of at the present day. This is Celandine (*Chelidonium majus*), which, in the form of a liquid extract, has enjoyed some measure of professional sanction both as a local application and as an internal remedy.

* * *

ADDISON ON IDIOPATHIC ANÆMIA.—The case of pernicious anæmia discussed at page 21 may remind some of our readers that we owe the first description of this disease to Addison. It is to be found in his celebrated monograph “On the Constitutional and Local Effects of Disease of the Supra-renal Capsules,” which was published in 1855. The description forms an introduction to the main purpose of that essay, which was, of course, to attract the attention of the profession to the morbid state now known as Addison's disease. In order of time, it appears that Addison's observations were first concerned with the form of anæmia which he termed “idiopathic,” and that it was “whilst seeking in vain to throw some additional light upon this” that he observed the association of the clinical condition

which bears his name with a pathological change in the supra-renal capsules. The paragraphs of the essay which deal with idiopathic (pernicious) anæmia are as follows:—

“For a long period I had from time to time met with a very remarkable form of general anæmia, occurring without any discoverable cause whatever—cases in which there had been no previous loss of blood, no exhausting diarrhœa, no chlorosis, no purpura, no renal, splenic, miasmatic, glandular, strumous, or malignant disease.

“Accordingly, in speaking of this form in clinical lectures, I perhaps with little propriety applied to it the term ‘idiopathic,’ to distinguish it from cases in which there existed more or less evidence of some of the usual causes or concomitants of the anæmic state.

“The disease presented in every instance the same general character, pursued a similar course, and, with scarcely a single exception, was followed, after a variable period, by the same fatal result.

“It occurs in both sexes generally, but not exclusively, *beyond the middle period of life*, and, so far as I at present know, chiefly in persons of a somewhat large and bulky frame, and with a strongly-marked tendency to the formation of fat.

“It makes its approach in so slow and insidious a manner that the patient can hardly fix a date to his earliest feeling of that languor which is shortly to become so extreme. The countenance gets pale, the whites of the eye become pearly, the general frame flabby rather than wasted; the pulse, perhaps, large, but remarkably soft and compressible, and occasionally with a slight jerk, especially under the slightest excitement; there is an increasing indisposition to exertion, with an uncomfortable feeling of faintness or breathlessness on attempting it; the heart is readily made to palpitate; the whole surface of the body presents a blanched, smooth, and waxy appearance; the lips, gums, and tongue seem bloodless; the flabbiness of the solids increases; the appetite fails; extreme languor and faintness supervene, breathlessness and palpitations being produced by the most trifling exertion or emotion; some slight œdema is probably perceived about the ankles; the debility becomes extreme. The patient can no longer rise from his bed, the mind occasionally wanders, he falls into a prostrate and half-torpid state, and at length expires. Nevertheless, to the very last, and after a sickness of, perhaps, several months’ duration, the bulkiness of the general frame and the obesity often present a most striking contrast to the failure and exhaustion observable in every other respect.

“With perhaps a single exception the disease, in my own experience, resisted all remedial efforts, and sooner or later terminated fatally.

“On examining the bodies of such patients after death I have failed to discover any organic lesion that could properly or reasonably be assigned as an adequate cause of such serious consequences; nevertheless, from the disease having uniformly occurred in fat people, I was naturally led to entertain a suspicion that some form of fatty degeneration might have a share, at least, in its production; and I may observe that, in the case last examined, the heart had undergone such a change, and that a portion of the semilunar ganglion and solar plexus, on being subjected to microscopic examination, was pronounced by Mr. Quekett to have passed into a corresponding condition.

“Whether any or all of these morbid changes are essentially concerned—as I believe they are—in giving rise to this very remarkable disease, future observation will probably decide.”

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THE PREVENTION OF RHEUMATIC ENDOCARDITIS.

AMONG the substantial advances in clinical knowledge which are to be credited to the latter part of the nineteenth century, the recognition of the varied forms in which rheumatism may express itself during the earlier years of life, well deserves to be numbered. The conception of the disease as an acute polyarthritis with the possibility of cardiac complications, though accurate enough in general terms so far as the adult is concerned, is now known to be anything but adequate to the facts of rheumatism in childhood. Here, on the contrary, we have such manifestations as chorea, erythema, anæmia, tonsillitis, subcutaneous nodules, &c., eclipsing the evidences of arthritis, which are, at least in the majority of cases, reduced to inconspicuous proportions. More important still, experience shows that with any one of these consequences of the rheumatic influence, even though exhibited in the slightest possible form, inflammation of the endocardium or pericardium, or of both, may be associated. And yet again, there is ample testimony that these last-mentioned results may be the most definite, and perhaps in some cases the sole evidence of rheumatic disease. Two general propositions may therefore be stated. First, that rheumatism in childhood reveals itself in many different forms. Secondly, that while its overt manifestations may be slight and non-obtrusive,

its effects on the heart are frequent and tend to be severe. Or to present the contrast between the adult and the child in reference to rheumatism in a single broad statement, we may say that in one the main stress of the disease falls on the joints, and in the other on the heart. Therefore, however strong the claim for care in regard to the heart in adults may be, it is immeasurably stronger in the case of the child. That the most effective method of protecting the patient from endocarditis is by enforcing a policy of complete rest so long as there is reason to believe that rheumatic tendencies are active, is universally admitted. The adult is in some measure driven to adopt this policy in virtue of the painful condition of his joints. But in earlier life this natural protective influence is largely wanting. The rheumatic child, even when the victim of the disease in an active phase, frequently suffers little or no pain, and thus is largely free from any compulsory restriction of his usual activities. It may be that this is an important factor in determining the greater frequency of rheumatic endocarditis in childhood. Whether this is so or not, it is beyond question that rheumatic children as compared with adults are peculiarly prone to develop endocarditis, and that in them rheumatism is apt to take active shape in forms that do not enforce the bodily rest by which endocarditis might possibly be avoided.

It seems reasonable to assume that a wider and more practical recognition of these clinical truths would probably do something to lessen the frequency of rheumatic endocarditis. What is wanted is an appreciation of the true import of illnesses which, on the surface, seem trivial, but are really of great importance in consequence of their rheumatic nature. This end can only be attained by the education of the public, and more particularly by the education of the parents of families in whom there exists a tendency to rheumatism. It is not enough that the medical profession recognises such incidents as a sore throat, a slight febrile attack, general weakness, "growing" pains, &c., as possible members of the rheumatic series and having endocarditis as a definite attendant risk. The fact that these and other events are signs of rheumatism, and that they carry with them a considerable probability of organic heart disease, must also be prominently before the minds of the parents, if children having a rheumatic

inheritance are to receive during their various illnesses the protective advantage of early, prompt, and complete rest. Only in this way is there any chance of obtaining such preventive influence as bodily rest is capable of exerting. From this it follows that the duty of the medical man who discovers the existence of rheumatism in any family under his professional care, is not restricted to the treatment of such evidences as they severally arise. On the contrary, it is plainly his mission to state beforehand and in clear terms the danger attending various apparently trivial illnesses, as these may affect the younger members of the household, and to urge the absolute necessity of meeting these conditions by complete rest, practised from the very onset of the signs of indisposition. Let it once be generally understood that this is a professional responsibility which, in the circumstances suggested, should never be omitted, and there will be a fair prospect of gaining for children in rheumatic families the measure of protection from endocarditis which bodily rest is competent to afford. At present, only too often the child comes under observation after the mischief is done. The history, though showing nothing regarded as rheumatism in the popular sense of the term, is of no uncertain significance to the physician; and a cardiac murmur is present. Such cases are frequent in the experience of every practitioner. Can nothing be done to prevent them? Possibly the bacteriology of the future—perhaps of the immediate future—may reveal prophylactic methods of which we, as yet, are ignorant. In the meantime, the practice of early and complete rest is our only available resource. This is usually not adopted, because the parents of families with rheumatic proclivities do not realise either the real significance of many of the illnesses from which their children are apt to suffer, or the serious risks of heart disease which these entail. It lies with the medical attendant to forewarn them on these points. And his opportunity to do so arrives when any event in the family medical history informs him that he is in contact with individuals who number among their special risks a tendency to rheumatic disease. To provide figures or statistics in support of the rule of practice here advocated is difficult or impossible, but it is surely not too much to say that its universal and effective adoption can profess a reasonable anticipation of some, and it may be a considerable, measure of success. By applying it,

the profession will at least be doing its best to place at the disposal of the public the influence which, so far as our present knowledge goes, is most likely to be successful in safeguarding rheumatic children from the disastrous complication of cardiac valvular disease.

C. O. H.

DECLINE OF LEPROSY IN MADEIRA.

A VISIT to a lazaretto is not usually an occasion of cheerfulness. There are, however, in the present condition of Funchal (Madeira), elements which inspire both gratitude and hope. It is a large establishment, and almost empty of patients. On December 10, 1901, there were only four inmates, and one of them was certainly not a leper. Dr. Gavin Milroy, fifty years ago, recorded his belief that leprosy was diminishing in Madeira, but he found that the average of admissions had been eight new cases a year. In 1829, Dr. Kinnis found in the home seventeen men and seven women. At present there are no women and, as we have written, only three men. No compulsion to enter the home or to remain in it exists now, or ever has done. The reduction in the number of inmates is therefore not due to any concealment of the disease in fear of forcible seclusion. Such being the satisfactory state of things, it is of much interest to ask what have been the causes which have led to it. No precautions whatever have been taken against contagion, other than the provision of a comfortable home for those who wish to avail themselves of it, and this does not prevent a considerable majority from remaining with their friends at home. The decadence of the disease has resulted from precisely the same class of causes which were brought to bear in England and the adjacent islands a few centuries ago. Our Norwegian *confrères* are exultingly attributing their own improved statistics to the partially compulsory measures of segregation which there, during the last few years, have been in force. But precisely the same general improvement in dietary is taking place amongst their peasantry that is occurring in Madeira, and it may be that to it, and to it alone, the gain is due.

MALARIAL ULCERS AND MALARIAL ERUPTIONS.

IN a case presented at the Polyclinic a year ago with numerous small pustules and sores on the wrists and forearms, which were attributed to malaria, the patient, an intelligent man, readily adopted the suggestion that they were mosquito bites which had festered. They were in all stages, and they occurred on the exposed parts. The man assured us that he had been much bitten in these parts. Dr. Kerr Cross writes of these affections: "Malarial ulcers may be in crops of pimples, or one sore the size of a shilling, or a large sore like the palm of the hand." This variety of form and condition makes it very improbable that they are direct results of the malarial poison. Dr. Cross adds the curious assertion: "When the sufferer has a sore he has no fever, and *vice versâ*." This needs further investigation. It may be that the large ulcers occur in those who have had syphilis. Sir H. H. Johnston has a sentence which supports this view.

Apart from the maddening irritation caused by its bites, the mosquito would appear to introduce some unwholesome substance, and when the person bitten is in a poor state of health, the mosquito bites turn to ulcers, which are difficult to heal until the sufferer is removed to a healthy locality.

EXAMPLES OF EXCESSIVE FEEDING.

INTERESTING illustrations of the policy of excessive feeding may be taken from insect life. It is well known that many caterpillars gorge enormously. Their growth at that period of life is very rapid, and so also is the development of their structure. But they do not use up a twentieth of what they eat. They defecate continually and to an enormous amount. Apparently their absorbent organs select what is wanted and disregard the rest, which is the bulk of what they have eaten. It is said that when a herd of nun caterpillars is feeding on the leaves of the spruce fir, the noise of their excre-

ment falling on the foliage is like that of a shower of rain. That the fæces are not merely *débris* ejected without change is shown by the fact that they are excellent manure, whereas the spruce leaves themselves are useless. So efficacious is this manure, that it is recorded respecting a year in which, in Bavaria, this caterpillar abounded, that the grasses grew most abundantly the following summer. It was further remarked as a secondary result, that the antlers of the wild deer in the forest were larger than they had ever before been noticed. In regions where locusts abound it is observed as a set-off to their injurious depredations that their very abundant excrement serves as an excellent manure. In this instance it is the mature insect which gorges itself, but it is still making growth.

CANCER IN SAVAGE RACES.

THE question as to whether cancer is or is not common amongst savage races is of great interest, and is perhaps not so nearly decided in the negative as some would have us believe. Dr. Long, medical resident in Maseru (Basutoland), told the writer that malignant growths were common there. Dr. Kerr Cross gives evidence respecting the Nyassa district and makes the cautious statement: "Cancer is not very common," adding that he had recently seen a woman with cancer of the breast who had travelled 450 miles to consult him.

LEUCODERMA IN KAFFIRS.—Dr. Kerr Cross, of North Nyassaland, writes of leucoderma that it chiefly affects the hand, but may appear on the lips, feet, and breast. He adds: "The natives say it is due to their eating a certain kind of fish. They say many people can eat the fish with impunity, but that if others eat it they are seized with this disease."

* * *

LATENT VITALITY.—It is reported on good evidence that the eggs of the locust may remain unhatched for eleven years, and may still be capable of development.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

SOME POINTS IN THE DIAGNOSIS AND PROGNOSIS OF HEART DISEASE.

[*Abstract.*]

BY E. MARKHAM SKERRITT, M.D.LOND., F.R.C.P.

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Bristol General Hospital.*

AFTER some preliminary remarks on the importance of the subject, the lecturer proceeded to discuss the relation of diagnosis to prognosis, and the factors entering into prognosis.

A complete prognosis entails:—(1) An accurate estimate of the nature and extent of the changes that have occurred, *i.e.*, a complete diagnosis; (2) A knowledge of the past history, with especial reference to the causation of the trouble and the length of time that it has existed; (3) An acquaintance with the course that may be run by a lesion such as is present; (4) A due weighing of the special features of the case in question.

When the heart is concerned error may arise, on the one hand, through mistake as to the actual physical condition of the organ—error in diagnosis; or, on the other, owing to failure to recognise what will be the resultant of the various forces which are rightly recognised as being at work—error in prognosis. In early life the discovery of the lesion is usually easy, but there are wide possibilities as to its future course. For youth is the time of acute inflammation, of acute pericarditis, and endocarditis, which are commonly discovered with ease; but no wisdom will avail to surely foretell the future while acute endocarditis is running its course. Whether when the inflammation subsides the roughened valve will be smoothed, and the murmur will disappear—or the

morbid sound will persist, but based on so little valve-change as to remain a murmur and nothing more—or whether the lesion is destined to work havoc with the heart and bring life to a speedy close ; all this is beyond the reach of human foresight. Diagnosis is simple, definite prognosis is impossible. Towards the other end of life the opposite tends to obtain. Degeneration has no distinctive physical signs ; and it often cannot be said with certainty whether the halting action of the organ is due to change which is organic and must remain, or comes from simple and remediable weakness. Prognosis would be easy were diagnosis certain.

It is important to recognise how far physical signs can be relied upon in heart disease as evidence of the nature and extent of the morbid changes present. It is well known that the quality of a murmur is no guide to the amount of valvular mischief which exists ; for while, on the one hand, the loudest murmur may remain for many years with quite unimportant results, on the other, the effects of a valvular lesion may sometimes be too grave for the production of a murmur at all. For it may happen that when the patient comes under observation there is no murmur, in spite of the other indications of most advanced defect of an orifice—the heart's action being for the time too weak to develop the murmur for which the other physical conditions exist—and as the organ gains strength the murmur becomes audible.

A true estimate of the gravity of a lesion can only be gained by a general survey of the case in the broadest light—to determine, first, what has been the effect upon the heart itself, and then how far its influence has extended beyond this organ. If it is found that a murmur is present, no matter at which orifice, and that there is no change in that part of the heart upon which the strain first comes ; and if it is also known that this murmur has existed long enough for the effects of increased work to be manifested ; then it follows that, whatever the character of the murmur, the lesion is trivial and practically stationary, and may remain so for an indefinite time. On the other hand, if hypertrophy, or dilatation, or both, are found to exist, their degree is a test of the actual interference with the heart in its work. Due weight must also be given to the character of the pulse, and to symptoms such as dyspnœa or palpitation or syncope, and to any evidence of

interference with the pulmonary or the systemic circulation—such as bronchitis or congestion of the lungs in the one, or dropsy in the other—or of the presence of associated disease elsewhere, particularly in the kidneys.

While in certain conditions the physical signs may thus attract more attention than is their due, there is an opposite group, especially associated with advancing years, where they are apt to be by no means proportionate to the gravity of the actual state. In this case an intelligent consideration of the symptoms is essential, since they are of greater importance than the physical signs. Angina pectoris from atheroma of the coronary arteries is an illustration in point. Special physical signs must be checked by general symptoms, not only when they are pronounced to a degree out of proportion to the actual lesion, but also where the reverse is the case—where they are indefinite notwithstanding the presence of grave disease.

The importance of “history” is never underrated by the practical physician. By it are determined the origin of any morbid state, the length of time that it has existed, and its tendency to development in one direction or in another; and an accurate appreciation of the information which it conveys is of the greatest value. Where valvular disease of the heart is due to acute endocarditis, it is important to know whether there is a liability to a fresh onset of the malady in which it originated. For instance, when endocarditis originated during the course of an acute specific fever, such as scarlet fever, which usually attacks a patient only once, the prospect is better than in the case of acute rheumatism, where recurrence is common, and often lights up fresh endocardial inflammation. Or the history shows that the murmur may be due, not to endocarditis, but to dilatation of heart following acute illness or originating in anæmia; in which event there is a reasonable prospect of cure. Or the cause is perhaps preventable or more or less removable, as when muscular strain produces cardiac enlargement. Or it is a diathetic condition, such as gout, which may be kept in check, but cannot be eradicated. Or the affection may originate in a persistent and irremediable condition, as when dilated hypertrophy results from chronic Bright’s disease or from the arterial degeneration of age. In every case a recognition of the cause of a cardiac lesion, and

therefore of the degree to which it may be influenced or removed, enters into a rational prognosis.

It is difficult to overestimate the value of a knowledge of the *length of time* that a heart lesion has existed. It is perhaps of greater importance in prognosis than any other factor, especially in the case of disease originating in acute inflammation.

Considered from the point of view of pathological anatomy, the result of acute endocarditis may be as follows :—

(1) Resolution, with removal of the products of inflammation, and consequent disappearance of all abnormal physical signs. This is exceptional, but experience favours the view that it sometimes occurs.

(2) Subsidence of the inflammation, with persistence of its products. This is much more usual. The young connective-tissue growth in the endocardium goes through the same changes which occur in the same tissue elsewhere—whether it be in the liver in cirrhosis, or in the cicatrix of a burn, or in the valves of the heart, as it matures it tends to contract, and as it contracts it distorts the part which is its seat. When the change of the products of inflammation into fibrous tissue is completed, acute endocarditis is at an end. Pathologically, therefore, the result in all hearts thus affected is the same—the persistence of the matured products of inflammation. But the practical difference between one heart and another is great. In the one, perhaps so slight a change that the valve, though permanently marked by inflammation, is practically perfect, and no murmur therefore exists—anyhow too trivial to give rise to definite interference with the function of the organ. In the other, the self-same morbid process results in some grave valvular deformity forming an obstacle before which the heart speedily fails. Pathologically identical, the outcome of the same affection, the clinical position of the two hearts is widely different.

(3) Recurrence of acute inflammation in the affected structures. This is especially likely to occur if the cause recurs, as is so often the case with acute rheumatism. But in the lecturer's experience it is not rare for this fever to recur without lighting up fresh endocardial inflammation.

(4) Passage of acute endocarditis into the chronic form. Opinion differs as to the frequency with which this occurs. This important

question is not adequately discussed by authorities on morbid anatomy; but clinical experience points to the view that while in some cases acute endocarditis comes to a definite end, in others there is reason to conclude that the mischief is progressive. The lecturer has met with many cases in which no alteration either in the character of the murmur or in the general state of the heart could be detected during, in some instances, a considerable number of years; and it is reasonable to conclude that if the condition of the organ is thus stationary from the clinical point of view, it also remains structurally unaltered. On the other hand, instances are only too common in which it is plain that the valvular lesion is progressive, and the obvious inference is that chronic endocarditis has carried on the mischief begun by the acute inflammation.

Thus the results of acute endocarditis vary within the widest extremes, and no data exist by which the ultimate position of any case can be foretold during an acute attack. The problem will be solved by time, and by time alone. Endocarditis must be estimated by its results—the damage which has been done to the heart in a given time is a test of what will happen in the future; and prognosis becomes a problem in proportion.

The only indication that a lesion is on the one hand grave or on the other unimportant is the degree to which the heart has become secondarily affected—the evidence showing that the organ is hindered in its work. The presence of hypertrophy, the existence of dilatation, and their amount; signs of defect in the conduct of the circulation in the lungs or in the systemic circuit—these are what have to be sought. And in relative gravity they come in the above order. When the obstacle to the circulation is not great, it may be overcome by hypertrophy, and thus the balance between work and power may be maintained. If dilatation exists, it shows that the valvular lesion is a cause of serious inconvenience to the heart, leading to its over-distension; and when it has once set in it tends to be progressive. Failure of compensation ushers in the last stage in progressive valvular disease, when the effects of back pressure are manifested; and death finally brings release from a condition of great misery.

Let it now be supposed that the patient comes under observation some considerable time after an attack of acute endocarditis—it may be twelve months, or two years, or longer—and that a

murmur is present. Prognosis becomes a problem in proportion. If the heart is in a certain state at the end of a certain time, what will be its condition in the future? And the longer the interval since the acute inflammation, the more certainly can this question be answered. If in the same period one patient has arrived at the stage of dropsical effusion, while another has a much enlarged heart, which can still overcome the obstacle to its work; and another is unconscious of disease, and there is but slight increase in cardiac size and strength; and in yet another no change whatever has occurred—the inference is plain, that as it has been in the past, so it will probably be in the future; disease that has advanced will continue to increase, that which has been quiescent will remain so still; and through the whole series the foundation of prognosis is time—time, and the changes which it has wrought.

An acquaintance with the course which is usually run by the various forms of heart disease is important, but often cannot be applied with sufficient accuracy to be of much value. It is, however, recognised that in valvular disease each form has certain general tendencies. Walsh makes the following descending series: tricuspid regurgitation, mitral obstruction, mitral regurgitation, aortic regurgitation, pulmonary constriction, aortic constriction;—tricuspid constriction and pulmonary regurgitation being too little known to be placed in position in the list. The worst results follow those lesions which directly obstruct the circulation behind them. The prospect is sometimes improved when some other valvular affection is added to that which already exists; for instance, there is less liability to sudden death in aortic regurgitation if associated with mitral regurgitation; and the advent of tricuspid regurgitation often relieves the pulmonary circulation in mitral disease.

The fate of hypertrophy and dilatation is bound up with that of their cause. As this is usually persistent and often progressive, the secondary cardiac enlargement is correspondingly permanent and tends to increase. The greater the hypertrophy in proportion to the dilatation, the better the prospect; but only while the nutrition of the heart remains good. When degeneration begins in the hypertrophied wall, the balance between work and power is disturbed, never to be restored. This is illustrated in the late history of chronic Bright's disease, leading to the symptoms of cardiac distress.

The liability to sudden death in heart disease is an aspect of great practical importance; and where there is no tendency to this the patient's fears should always be relieved. The valvular lesion which carries with it by far the greatest risk of sudden death is aortic regurgitation; and the liability is proportionate to the degree of valvular incompetence. The same accident may result from dilatation, and from rupture of the heart or of an aneurism of the heart. The degenerations, however, supply the majority of the instances of sudden death, as in angina pectoris from fatty degeneration of the heart, or affections of the coronary arteries interfering with the nutrition of its walls. But a fatal result is most imminent when the degenerate heart has to face increased arterial tension.

The last division of prognosis—the consideration of the special features of a given case—includes many factors, such as social status, sex, temperament, and general habits, and the condition of the other organs. Excepting the last, perhaps the most important is position in life. If the sufferer from cardiac trouble can be placed under the most favourable conditions, his prospects differ much from those of another who has to work for his bread in the calling which he may chance to follow. After acute endocarditis it is of the greatest importance to save the heart all but absolutely necessary work for some considerable time; and this can only be done in the case of the well-to-do. And in chronic valvular disease the outlook varies much with the ability of the sufferer to order his way of life aright.

The lecturer concluded with a reference to the uncertainty attending prognosis in heart disease, illustrating this by citing instances where error had arisen; and he strongly urged the wisdom of allowing for possibilities as well as probabilities, and giving the patient to the full the benefit of such doubt as may attach to his condition.

ON ECTOPIC GESTATION.

BY J. HALLIDAY CROOM, M.D., F.R.C.S., EDINBURGH.

[*Abstract.*]

THE lecture was concerned for the most part with ectopic gestation as this presents itself as a practical problem to the general practitioner. Exceptional or doubtful forms, such as the alleged primary abdominal and ovarian varieties of extra-uterine pregnancy, were excluded, as being at best but clinical curiosities, and having little or no claim on the attention of those concerned with actual events. The subject was thus restricted to the tubal form of ectopic gestation. Even here, it was pointed out, there are varieties which have but little clinical importance. A pregnancy occurring in the portion of the tube which passes through the uterine wall, (interstitial tubal) cannot be diagnosed in its early stages, and should it proceed to a more advanced degree of development, it is then indistinguishable from a pregnancy in one horn of a bicornate uterus. Again, if an ovum becomes detained and fertilised at the ostium of the fimbriated extremity of the tube (infundibular tubal), it, in the vast majority of cases, falls into the cavity of the peritoneum (tubal abortion), and either becomes absorbed or remains without further development (tubal mole). All these, unless in very exceptional circumstances, are outside the demands of actual clinical work. On the other hand, the common form of tubal pregnancy, viz., that in which the ovum is detained and undergoes development in the middle third (ampulla) of the Fallopian tube, is a clinical event of the first moment. Allowed to pursue its natural course, it is almost certain to bring the woman into imminent risk of losing her life; whilst this danger may be anticipated and prevented by a diagnosis of the condition prior to the supervention of acute symptoms, and by the prompt performance of an operation which is neither difficult nor charged with much measure of risk. There is therefore an urgent demand that the family practitioner should be prepared to recognise and deal with this condition.

The life history of such a tubal pregnancy as is above described, consists, at first, of a gradual enlargement of the sac with corresponding thinning of its wall. Should rupture occur early, say about the second or third week, the symptoms will probably be limited to a slight attack of pain in one or other side of the lower abdomen, with a sensation of faintness and some appearance of pallor. There must, of course, be some hæmorrhage into the cavity of the peritoneum, but this can rarely need surgical treatment, and if it and the fœtus are not absorbed, they remain, at the worst, to form a mole having little or no practical importance. But if rupture is postponed to a later stage, say from the eighth to the twelfth week, when the vascularity of the sac has become considerable, the position is a much more serious one. If rupture occurs at a point on the upper border of the sac (intraperitoneal rupture), there will be an immediate and severe hæmorrhage into the general peritoneal cavity, and the woman may die in the course of an hour or so. But should the sac give way at its lower part, the blood will accumulate between the layers of the broad ligament (extraperitoneal rupture). The resistance offered by these layers will necessarily prevent the hæmorrhage taking place rapidly. In time, it is true, they may be stretched so as to accommodate an enormous volume of blood, but this process cannot be accomplished promptly, and hence rupture of the sac of a tubal pregnancy in a downward direction never produces the dramatically sudden death which is likely to follow rupture into the general cavity of the peritoneum.

The symptoms of an intraperitoneal rupture are sudden, agonising pain; pallor, syncope and other signs of internal hæmorrhage, and rapid death. The only possible treatment is immediate abdominal section to secure the bleeding point. When symptoms such as the above develop, it is impossible, in the absence of a full history of the case—and for the collection of this there is no time—to distinguish between a ruptured extrauterine pregnancy and an acute hæmatocele. The latter will almost certainly recover without operation, and hence a practitioner suddenly summoned in the circumstances just described is in a position of great difficulty. Perhaps the wisest course, unless there are definite reasons against it, is to operate, even at the risk of finding that this has

been unnecessary. In extraperitoneal rupture the symptoms are less acute and less extreme than in the intraperitoneal form, but here also the treatment is by operation. The distinction may have to be made between this condition and hæmatocele (pure) with the fluid in Douglas' pouch. In the latter condition the uterus is floated upwards, and there is apt to be retention of urine and rectal tenesmus.

The above statements present the possibilities which attend a tubal pregnancy when it is allowed to pursue its natural course. Such a policy is very apt to lead to the emergencies just defined. The proper treatment of tubal pregnancy, however, is to anticipate these emergencies by diagnosing the condition before rupture occurs, and to operate immediately the diagnosis is completed. It was the main purpose of the lecture to emphasise this proposition. The following rules for diagnosis were presented as applicable to a tubal pregnancy about the eighth to the tenth week of gestation.

(1) The reflex signs of pregnancy may be present. This is more especially true of the mammary signs. Thus milk may be found at an early date. The value of the pigmentary changes in the breasts is qualified by the fact that extrauterine pregnancy is not so frequent in primipara as in multipara. Morning sickness is not common.

(2) There is usually a history of a long interval between an extrauterine pregnancy and the immediately preceding pregnancy. The fact of a relatively recent pregnancy is therefore opposed to the diagnosis of extrauterine pregnancy.

(3) A history of some form of disease of the uterus or appendages is common. It has been taught that in every case of ectopic gestation there has been a previous desquamative salpingitis, which, by destroying the ciliated epithelium of the Fallopian tube, renders it possible for the ovum to be detained in the tube. Though this is not literally true, it is certain that extrauterine pregnancies occur much less frequently in women with healthy, than in those with diseased pelvic viscera.

(4) The menstrual history which is suggestive is one stating that a single period has been missed, and that subsequently irregular hæmorrhages have occurred. A history of complete amenorrhœa for two to three months rarely means extrauterine pregnancy.

(5) Vaginal examination detects (a) the existence of a cystic swelling which is tense and sensitive, and in which there is pulsation. The cyst is never movable, and is situated either to one or other side of the uterus, or behind the uterus. If to one side, the uterus is pushed over towards the opposite side of the pelvis. (b) The os uteri is patulous and enlarged. (c) The uterus is enlarged; this enlargement takes place during the first three months just as in a normal pregnancy, but does not advance beyond this point. It is to be noted that the vaginal examination should be made with the patient fully anæsthetised; and it must be conducted with great gentleness, otherwise the cyst may be ruptured.

(6) Expulsion *per vaginam* of the decidua, in whole or part.

The treatment, when a tubal pregnancy has reached a period between the eighth and twelfth week, is prompt operation. To this rule no exception can be admitted.

The lecture, as already explained, dealt only with the variety of extrauterine pregnancy which is comparatively common, and which may at any time come within the responsibility of the practitioner. It was illustrated by various diagrams; and a synopsis, together with a clinical sketch of typical cases, was placed in the hands of each member of the audience.

SAMUEL PEPYS, who was born in 1632 and died 1703, was a victim to stone in the bladder. He was descended from a Norfolk family, and a tendency to stone is described as being "hereditary in his constitution." In his "Diary," under date March 26, 1660, he writes: "This day it is two years since it pleased God I was cut for the stone at Mrs. Turner's in Salisbury Court. And did resolve while I live to keep it a festival, as I did the last year at my house, and for ever to have Mrs. Turner and her company with me. But now it pleased God that I am prevented to do it openly; only within my soul I can and do rejoice, and bless God, being at this time, blessed be his holy name, in as good health as ever I was in my life." The circumstances which in March, 1660, prevented Pepys from keeping the festival "openly" were associated with the fact that at that date he was with the fleet that subsequently sailed to the Hague to return with Charles II. He was thus actively concerned with the events which immediately preceded and accompanied the Restoration. Pepys was President of the Royal Society during the years 1684 and 1685.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY HARRY CAMPBELL, M.D., F.R.C.P.

Tuesday, January 7, 1902.

A Case of Syphilitic Hemiplegia.

THE objective facts in this case were in no way unusual. The history, on the other hand, carried a practical lesson of no small importance. In the first place, it was quite beyond doubt that the patient, a man of 31 years, had suffered from constitutional syphilis. In the second place, prior to the development of right hemiplegia he had complained of a sense of numbness affecting the fingers of the right hand. This was presented as a fact strongly supporting a diagnosis of thrombosis as against one of hæmorrhage. A definite history of premonitory sensory disturbances prior to a hemiplegic seizure always has this significance. With a history of syphilis, as here, there can be little doubt that the thrombosis depends on a specific endarteritis. The arterial calibre in the affected vessel is this way invaded, and the blood supply to the corresponding brain area diminished. Hence various symptomatic disturbances. These may take such forms as giddiness or headache, or may appear as peripheral sensations in such complaints as tingling, numbness, etc. In time, the occlusion of the artery becomes complete, the final closure being effected by the formation of a thrombus on the surface of the gummatous patch. Hence complete anæmia and softening of the involved area of brain tissue, and should this be, as it frequently is, a portion of the motor tract, there will be more or less extensive paralysis on the opposite side of the body. These

considerations explain both how it is that the actual hemiplegia in a case of thrombosis may be of sudden onset, and also the existence of the sensory disturbances which precede the paralytic seizure. They have also a very obvious and direct bearing on treatment. For there is no doubt that potassium iodide, given in full doses, will, at least in the majority of cases, remove gummatous deposits in the walls of the cerebral arteries just as it will remove similar formations in other tissues. But when complete occlusion of an artery has taken place, with consequent cerebral softening, neither potassium iodide nor any other remedy will restore either the vessel or the degenerated brain tissue to the *status quo ante*. Hence the extreme importance of recognising the real significance of such premonitory symptoms as giddiness, headache, numbness or tingling in the limbs, etc., in persons known or suspected to be the subjects of syphilis. These all tell of specific changes in the cerebral vessels, and they all therefore demand full doses of potassium iodide, with a view, not only to relieve the patient of his present discomfort, but also to avert consequences yet more disastrous. This is the practical lesson which the case enforces. All that potassium iodide can now do for the present patient is to check any specific endarteritis that may exist in vessels still pervious. It cannot unlock the occluded artery, nor restore the efficiency of the damaged brain area. Had it been energetically administered when the patient first complained of tingling in his fingers, the probability is that he would not to-day have been the victim of hemiplegia. One other fact may be mentioned as supporting the diagnosis of thrombosis. It is that the onset of the paralytic attack was not accompanied by loss of consciousness. Such loss is far more frequent when the cause of the hemiplegia is a hæmorrhage, than it is when the paralysis is due to thrombosis.

A Complete Denture in Middle-age.

This man was presented as unusual in respect of the fact that though 49 years of age he could boast the possession of thirty-two teeth, no one of which presented the least sign of caries. The crowns of the teeth were "ground down," and from observations made by Dr. Campbell, he was convinced that the man masticated

his food with much more than customary thoroughness. He argued therefore that efficient use of the teeth is a factor in promoting their preservation. He further suggested that, as diligent mastication cultivates the development of the jaw, it will also, both mechanically and by securing a better blood supply, tend to the more perfect expansion of the pharyngeal and nasal cavities, at least if practised in early life. Such expansion must needs diminish the probability of nasal obstruction by adenoids or other abnormal conditions of the nose and pharynx. Hence was urged the desirability of cultivating the habit of mastication in infancy and early childhood. To effect this, it is necessary to correct the widely prevalent practice of keeping children in their early years entirely to fluid or pulpy foods. With the introduction of more solid articles of diet would come the habit of more prolonged mastication, and as a consequence, a better developed naso-pharynx and less chance of nasal obstruction.

Other cases included : (1) A lad with infantile paralysis affecting both upper limbs ; (2) a patient with diabetes, absence of knee-jerks, and marked muscular weakness ; and (3) a middle-aged man, the subject of tachycardia associated with attacks of gastric disturbance.

MEDICAL CASES.

BY C. THEODORE WILLIAMS, M.D., F.R.C.P.

Tuesday, December 17, 1901.

THE patients attending on this date were :—

I.—Two Cases of Mitral Regurgitation.

In one the patient, though only 18 years of age, had suffered from severe general anasarca, and œdema of the lungs. There was widespread pulsation over the præcordium, with some retraction of the intercostal spaces coincident with the ventricular systole ; the præcordial dulness was much increased both to the right and left ; and the pulse was labouring in character. Upon these facts Dr. Theodore Williams expressed the opinion that in

addition to the mitral disease there was probably also an adherent pericardium.

II.—*A Case of Phthisical Cavity at the Base of the Left Lung.*

The patient had suffered from pleurisy at the left base, and the resulting fixation of the lung in this situation was offered as the explanation of the site of the tuberculous lesion. Normally, of course, the apex is the position in which pulmonary expansion is at a minimum, and it is here for the most part that the activities of the bacillus take origin. But when the base or other part becomes fixed by pleural adhesions, conditions are established which favour the growth of the bacillus. Hence a basic pleurisy may be followed by pulmonary phthisis commencing at a situation corresponding to that of the original disease.

III.—*A Patient with Sacculated Bronchiectasis affecting mainly the Right Lower Lobe.*

Well-marked bronchial breathing was heard, but there was little or no percussion dulness.

IV.—*An Extreme Case of Rheumatoid Arthritis in a Woman of 34 years.*

SURGICAL CASES.

BY W. H. A. JACOBSON, M.Ch.

Thursday, January 9, 1902.

A Case of Tertiary Syphilis.

THE patient, a man of about 30 years, was sent for consultation in consequence of the repeated development of gummata in various parts of his body. Recently his throat had become extensively affected, and there was a large ragged ulcer on the soft palate, penetrating deeply and threatening perforation. Treatment had been by mercurial inunction, with the internal administration of potassium iodide, and the application of chromic acid to the throat. In commenting on the case Mr. Jacobson remarked on the depressing influence produced by serious syphilitic lesions either of the eye or the throat. In the one case the patient fears he will lose his sight, in the other he is unable to take an adequate supply of food. Mr. Jacobson emphasised the great importance of securing the

generous nourishment of syphilitic patients. He considers this a condition essential to the success of mercurial treatment when needed in the tertiary stage. Hence the state of the teeth should always receive attention. Another influence in the same direction is the protection of the patient from chill, by the use of proper clothing, and otherwise. The effect of chill is to check the action of the skin, and this interferes with the therapeutic action of the mercury, so far at least as syphilis is concerned. What is desired in the mercurial treatment of syphilis is a gentle passage of the remedy through the tissues, and this will be interfered with if elimination is repressed. The gradual action of mercury on the tissues is best obtained, Mr. Jacobson considers, by the administration of small doses of grey powder. He has no sympathy either with mercurial inunction or hypodermic injection. Regarding the present patient, he advised that an attempt should be made to attain to a more generous dietary. As in many other cases where patients are reduced to fluid food, there is a danger that this part of the treatment may be neglected. Such neglect is peculiarly apt to extend to the vegetable foods, the diet consisting solely of milk and meat extracts. Hence he suggested here the use of pulped vegetables, orange-juice, etc. He also recommended the use of stimulants, more particularly in the form of a few glasses daily of a good Australian Burgundy, which, with the addition of lemon-squash, makes a palatable drink. He would continue the potassium iodide, but would combine it with aromatic spirit of ammonia and tincture of cinchona. For local application to the ulcer of the velum he would use strong nitric acid, followed by a lotion containing perchloride of mercury, 1 gram. ; honey, $\frac{1}{2}$ oz. ; water to 8 ozs., and, if possible, the patient should be sent for a time to the seaside.

A Case of Epithelioma of the Lip.

The patient, a man of 38 years, had had a sore on the left half of his lower lip for five months. He had now a considerable tumour, about the size of a cherry, and with a definitely indurated base. There was some enlargement of a gland at the left angle of the jaw. Discussing the prognosis, Mr. Jacobson commented on the frequency with which cases of epithelioma reach the surgeon at a stage when secondary extension has already occurred. Though regarded as the

least malignant of the various forms of cancer, and developing for the most part in situations where it promptly attracts attention, the prognosis of epithelioma in individual cases is only too often a very bad one, for the simple reason that surgical treatment is postponed. It ought to be securely fixed in the mind of the practitioner that every moment's delay in the case of an epitheliomatous ulcer, however small this may be, is fraught with danger. How soon after the appearance of the ulcer the glands may become involved it is impossible to say, but it is certain that the interval may be as short as fourteen days. In the present case there could be no doubt that the glands were the site of a mixed infection—malignant and septic—and this condition was one of which rapid spread was a certain attendant. It was justifiable here to remove the primary tumour, but it was impossible to doubt that ere long there would be secondary malignant growth in the patient's neck. Even the operation on the primary growth would have to be more extensive than at first sight seemed probable. For while the main mass of the tumour projected forwards, it was found on everting the lip that the growth could be traced downwards so as to involve the reflexion of the mucous membrane on to the surface of the gum. Failure to recognise this extension in some cases led to recurrence *in situ*—a result which ought never to occur.

A Severe Case of Lupus.

The child, of whom we are able to present two photographs (p. 78), was described by Mr. Jacobson as the worst example of lupus he had ever seen. The first photograph was taken in March, 1901, the patient then being 7 years of age, and the disease having been in progress some four years. It shows generally the extreme severity of the disease, and an index of this may be observed in the extension to the forehead—a very unusual event. The destruction of the bridge of the nose is the result, not of lupus, but of inherited syphilis. Under observation the right cornea became cloudy and the eyeball disorganised. The condition of the right lower lid allowed the tears to pass over and irritate the cheek, and this for some time obviously prevented healing of the ulcerated surface. Ultimately, the sight of the eye being lost, Mr. Jacobson excised the lachrymal



Mr. Jacobson's case of Lupus. (From a photograph, March, 1901.



Mr. Jacobson's case of Lupus. (From a photograph, January, 1902.

gland, with a very beneficial result. It will be observed in the first photograph that the nostrils are reduced to two narrow slits. Even these were useless for respiratory purposes, in consequence of the existence of crusts, etc., within the nasal cavity. The improvement in this respect is well shown in the second photograph. An important element in securing that improvement was the maintenance in each nostril of a small piece of catheter, each of which was kept *in situ* by a looped thread passed round the ear, and the child had been taught to remove and replace the tubes herself. Mr. Jacobson emphasised the great importance of securing patency of the nostrils in lupus affecting the face and nose. Otherwise, though cicatrization is obtained and the patient's appearance so far improved, he may be unable to procure employment in consequence of the noisy character of the respiration. The local treatment of the lupus area had been as follows:—After removal of the scabs, and the application for some days of hot boracic fomentations, the whole of the ulcerated surface, including the mucous membrane covering the gums and inside the lips, was thoroughly scraped with a sharp spoon, and afterwards cauterised with silver nitrate. This was repeated on three occasions, at intervals of a fortnight or so, the face between times being covered, at first with boracic fomentations, and afterwards with a lotion of perchloride of mercury. The result of these measures was very satisfactory. Afterwards the child was sent to the country for three months, with great benefit to her general condition. The local treatment recently had been an ointment of yellow oxide of mercury (2 grains to the ounce). From the outset, the patient was given half a grain of grey powder thrice daily. The facts of the case specially worthy of note are: (1) The severity and extent of the disease, (2) the value of scraping and cauterisation, (3) the relatively inconspicuous and supple cicatrix so produced, (4) the beneficial change effected in the state of the nostrils by the persistent use of drainage tubes, and (5) the advantage of removing the lachrymal gland when, the eye being destroyed, the tear-secretion, by running over the cheeks, prevents healing of the lupus surface. To these may be added the necessity of seeing the patient every three to six months for some years, in order to make certain that any reappearance of the disease is met by prompt repetition of the local treatment.

SURGICAL CASES.

BY JAMES CANTLIE, M.B., F.R.C.S.

*January 8, 1902.**Pott's Curvature Treated by Forcible Straightening of the Spine.*

DR. OUTTERSON WOOD related the history of this case. The patient, a boy of 12 years, had enjoyed good health until 10 years of age. He then developed evidences of spinal curvature high up in the dorsal region, and was treated by a plaster jacket for some eighteen months. Soon after its removal, pressure symptoms appeared, and he was admitted to the West-End Hospital for Nervous Diseases. There was then complete spastic paraplegia. The lower limbs were quite rigid and useless; patella and ankle clonus and Babinski's sign were all present; and there was anesthesia of the lower limbs, and of the trunk up to the level of the umbilicus. The functions of the bladder and rectum were undisturbed. The angular curvature in the upper dorsal region was conspicuous. In this condition the lad was seen by Mr. Cantlie, with a view to the institution of surgical treatment. As there was a considerable amount of tenderness over the curvature, it was decided to advise a period of complete rest before proceeding to more active measures. After two months, though the tenderness had disappeared, the condition of the lower limbs remained unchanged, and forcible straightening of the spine was attempted. The result had proved eminently satisfactory, and the patient as shown at the Polyclinic appeared to be in every respect a healthy and active lad. The curvature was anything but marked, and the gait betrayed no abnormality. Mr. Cantlie described the method of forcible straightening, and discussed the conditions favouring its adoption.

Division of the Ulnar Nerve at the Wrist.

The patient had some months ago cut his wrist by thrusting his hand through a pane of glass. The accident was attended by division of the ulnar artery, which was ligatured. Subsequently,

atrophy of the hypothenar eminence and anæsthesia in the area of distribution of the ulnar nerve appeared, showing injury of the nerve. Mr. Cantlie drew attention to the frequency with which such a result follows accidents of this character, and to the readiness with which injury to the nerve is overlooked at the time. The hæmorrhage, of course, claims attention to the artery, and the possibility of division of the nerve is apt to be forgotten. Any wound of the artery at the wrist may obviously also involve the nerve trunk. Hence, in fixing the limb after ligature of the vessel, the wrist should be kept flexed, in order to approximate the divided ends of the nerve. If this is not done, there may be, as in the present case, the development of muscular atrophy, &c. The claim is all the more urgent because of the difficulty at a later stage of dealing effectively with the situation. The cut ends of the nerve become engaged in scar tissue, and in their dissection from this, and in the making of raw surfaces to secure union after suture, there is necessarily loss of substance. At the wrist this is a serious matter, because it is difficult to secure approximation of the ends. This arises from the fact that in this situation the nerve is closely bound down by its anatomical connexions, and, also, because the nerve runs in a straight line within its sheath. In the upper two-thirds of the forearm, approximation of the cut ends is quite compatible with the loss of a considerable piece of the nerve. Here, and indeed in the rest of the nerve as traced up to the brachial plexus, the nerve is arranged spirally within its sheath, so that it is capable of being considerably elongated by stretching. This spiral arrangement is found in many nerves, and reaches its highest development in those organs, such as the penis and tongue, which vary in length with varying circumstances.

A Case of Jacksonian Epilepsy.

This patient complained of "fits" limited to the right side of his body. He had suffered from them for five years, and at one time had as many as 130 attacks within forty-eight hours. Any doubt as to the substantial accuracy of his statements was removed by the occurrence of a paroxysm whilst he was under observation. The convulsion commenced in the muscles of the right thumb, rapidly

spread throughout the whole of the upper limb, and extended also to the right lower limb and right face. It was not possible to obtain a reliable history from the patient. All that could be learned was that he had fallen and injured his head in 1896. On the left side of his skull was an extensive scar, obviously due to a trephining operation.

SURGICAL CASES.

BY JONATHAN HUTCHINSON, JUNR., F.R.C.S.

Thursday, January 23, 1902.

Two Cases of Popliteal Aneurism.

EACH of these cases had been treated by ligature of the femoral artery in Hunter's canal. The elder patient, a man of 53 years, admitted a history of syphilis some twenty years ago. He was an auctioneer's porter, and in the course of his occupation was frequently called on to lift heavy objects. Probably this, rather than the syphilis, afforded an explanation of the development of the aneurism. The younger man, aged 24 years, was by occupation a plumber and gas-fitter. He gave no history of syphilis, had always enjoyed good health, and had no knowledge of any injury or strain of his limb. The diagnosis in each case had been quite free from difficulty. In each patient there had been a tumour, having an expansile pulsation and a distinct bruit, in the popliteal space; the tumour diminished in size and lost its pulsation when pressure was exercised on the femoral artery, and on removal of the pressure the pulsating tumour reappeared. The result of both operations was entirely satisfactory. The aneurism was found to be now represented only by a small firm knot. Each patient had full use of his limb and was free from pain and discomfort. The operations had been performed some three months ago, and Mr. Hutchinson drew attention to the fact that whilst the collateral circulation had been established to an extent sufficient to secure effective nutrition of the tissues below the knee, it had hardly yet advanced so far as to produce appreciable pulsation in the anterior

and posterior tibial arteries. This latter result is often delayed for six to twelve months after operation. The expectation of finding such pulsation in the course of a few weeks has no justification in experience. Discussing the various methods of treating popliteal aneurism, Mr. Hutchinson dismissed the practice of pressure—either immediate, by forcible flexion of the knee joint, or remote, by compression of the trunk of the femoral artery—as slow, tedious, uncertain, and free from advantages to counterbalance these defects. Ligature of the femoral artery on the proximal side of Hunter's canal, as at the apex of Scarpa's triangle, is occasionally found to be followed by reappearance of the aneurism, as it permits the establishment of a too free and abundant collateral circulation. The question lies therefore between excision of the aneurism, and ligature of the artery in Hunter's canal. It has been urged that the latter method leaves a firm mass in the popliteal space, which, by pressure on the internal popliteal nerve, produces a sense of dragging, and shooting pains in the distal part of the limb. The two cases now presented were offered as experiences contradicting this assertion. The younger patient admitted occasional coldness in the limb, but this was only of temporary duration, and each of the men affirmed his entire freedom from pain and from disability in the use of the affected limb; and the only local evidence of the aneurism was an inconspicuous firm tumour, hardly appreciable except on careful examination. It was argued that neither excision nor any other treatment could be expected to give a more completely satisfactory result. Further, as against excision, it must be remembered that the latter operation is a much more formidable one. The dissection of a considerable pulsating tumour under the anatomical conditions provided by the popliteal space is a task of some delicacy, and offers the risk of damaging both the popliteal vein and the internal popliteal nerve. Ligature of the artery in Hunter's canal avoids these difficulties and dangers, and gives, as seen in the present patients, a distinct and unqualified success. Excision has its value in the case of traumatic aneurisms situated in unusual positions, as, for example, in the hand or foot, as these are usually small in size, and can be dissected out without risk of injury to neighbouring structures. In describing the operation for ligature of the femoral artery in Hunter's canal, Mr. Hutchinson drew attention to the line

of incision, which is found by drawing a line from a point midway between the symphysis pubis and the anterior superior iliac spine to the posterior border of the internal condyle of the femur. From a point on this line situated a hand's breadth above the adductor tubercle of the internal condyle, the incision is prolonged upwards for some four inches. The tendency is to make the incision too far out, thus missing the anatomical guidance of the sartorius muscle, and cutting down on the vastus internus. Even if this is done, the direction of the short muscular bundles of the vastus internus downwards and outwards ought to save the surgeon from confusing it with the long bundles of the sartorius passing downwards and inwards. If he does not make this distinction, he may burrow among the fibres of the vastus internus in a vain search for the vessel. But should he realise his mistake, he will merely have to modify his linear incision so as to form a small flap folding inwards, in order to reach the position of the artery. This means a waste of time, which, as well as the risk just described, may be avoided by carefully selecting the line of incision in conformity with the surgical landmarks above defined. For the occlusion of the artery, and indeed in all circumstances in which a ligature has to be left under the skin, Mr. Hutchinson prefers kangaroo tendon. He has never found it to fail, and in time it becomes completely organized into a firm band of fibrous tissue.

A Case for Diagnosis. (?) Mycosis Fungoides.

In this case the patient, a man of 50 years, was the subject of a curious eruption affecting the eyelids, cheeks, and lower forehead. It had been present for at least five years. The eruption, which was roughly symmetrical, was in the form of discrete patches, of a light red colour; definitely infiltrated and raised above the skin, and having a slightly fissured or eczematous surface. There were, in addition, on some of the patches, and also in the areas of skin between the patches, some scattered yellowish points which, on pressure, yielded a gummy exudation of a yellow colour. There was decided enlargement of the pre-auricular gland on the right side and also of some of the lymphatic glands in the neck. The man had had undoubted syphilis some fifteen years ago. The

question was therefore raised whether the condition of his face is to be attributed to syphilis. Against this diagnosis is the persistence of the eruption for so long a time as five years; its resistance to specific treatment, and its non-resemblance to any recognised syphilitic lesion. Apart from the character of the eruption, the glandular enlargement, and the fact that the patient had some dry erythematous or eczematous patches on his lower limbs, might be advanced in favour of a diagnosis of mycosis fungoides. Patches of this nature are known to frequently precede or accompany that disease. On the other hand, the patient had never had any erysipelas-like outbreaks on his face. This is a well-known feature in the clinical history of mycosis fungoides. The patient, in such circumstances, has a high temperature, and locally there is an acute dermatitis, on the subsidence of which a definite aggravation of the eruption is appreciable; and such attacks occur again and again. The treatment of mycosis fungoides is most unsatisfactory. Whatever agent is used to destroy the patches, they invariably return. The result is the same even when the patches are excised.

(?) *Lupus or Congenital Syphilis.*

The condition of the face and lips in this patient, a woman about 23 years, could hardly claim anything more than a diagnosis of lupus. But the position was complicated by evidences of extensive cicatrization in the fauces and pharynx identical with the effects not infrequently produced in the later stages of inherited syphilis. Thus arose the question whether the skin lesion was syphilitic in nature. The left cheek and the lips showed a considerable degree of chronic inflammatory infiltration, which extended also to the mucous membrane of the lips and gums. It had been present for many years. The nose was not deformed, nor the nostrils narrowed. On investigating the history, it was discovered that the patient's voice had long been affected, and particulars obtained from Dr. Taylor, of Derby, showed that so long as 15 years ago there had been stenosis of the larynx needing intubation and tracheotomy. Evidences of former ulceration in the fauces and pharynx were present in the shape of narrowing, with cicatrization,

and adhesion of the soft palate to the posterior pharyngeal wall. It was certain that this condition was much more suggestive of syphilis than of lupus. On the other hand, the face lesion was more like lupus than syphilis. It might possibly be that the case was one of lupus occurring in a syphilitic patient—a not uncommon group. There was, however no family history or evidence of specific taint, and neither in the patient's physiognomy, nor indeed in any part of the body, other than the pharynx, were there facts which could be urged in favour of such a diagnosis. There was a small nebula in one cornea, but nothing to prove a former interstitial keratitis. Perhaps a very critical survey might have insisted on some prominence of the frontal eminences, but this was not more than may be observed in many perfectly normal individuals.

DISEASES OF THE EYE.

BY R. MARCUS GUNN, F.R.C.S.

Friday, January 17, 1902.

A Case of Retro-bulbar Neuritis.

THE patient was a young woman of 20 years, a teacher in a board-school, and much occupied with studying for examinations. She regarded herself as in good health until a month ago, when the sight of the left eye suddenly became so seriously impaired that she was only able to see large objects with it, and even these appeared shadowy and ill-defined. At the same time she had some headache and giddiness; the eye "felt too large"; and the movements of the globe, as in looking to one or other side, caused pain. On examination it was found that vision in the left eye was very seriously reduced; the perimeter detected a considerable blind area in the centre of the visual field (absolute central scotoma), with relatively good peripheral vision; with the ophthalmoscope the fundus appeared

fairly normal, except for slight pallor, and some indistinctness of the edge of the disc; the left eyeball was tender to palpation; and the left pupil, though it contracted to direct light stimulation, did so only momentarily, the contraction almost immediately giving way to a state of dilatation. These symptoms and signs indicated the existence of a lesion in the trunk of the optic nerve behind the eyeball (retro-bulbar neuritis).

The stages which lead to that diagnosis may be presented in the following fashion. It is certain that the loss of sight in the left eye is not due to an ordinary intraocular neuritis, or to retinitis, for the fundus is practically normal to ophthalmoscopic examination. It is equally certain that the lesion causing the impaired left vision is not situated either in, or behind, the optic commissure, for such a lesion must needs, in consequence of the partial decussation of the nerves in the commissure, affect the visual field of each eye (hemianopsia). Therefore, by a process of exclusion, apart from other reasons, the lesion in such a case must be recognised as situated between the commissure behind, and the eyeball in front—that is, in the retro-ocular portion of the nerve trunk. This diagnosis harmonises with the other facts of the case. It explains the pain produced by movements of the eyeball, such movements straining the inflamed tissues round the nerve; the tenderness caused by pressure on the globe is similarly explained. Again, a lesion in the position here predicated, is known to have a special disposition to involve the nerve-fibres which take origin in the macular region (papillo-macular bundle), and upon which central vision depends. Hence the development of central blindness, with some retention of peripheral visual perception. And lastly, the merely momentary contraction of the pupil to light shows that the afferent fibres in the optic nerve are damaged to such an extent that their capacity for response to stimulation is rapidly exhausted. A still further proof of the situation of the lesion is afforded by the observation that whilst the direct light response in the left eye is defective, stimulation of the right retina produces effective contraction of both right and left pupils. The centres and efferent nerve-fibres which govern the left pupillary response must therefore be in a normal condition. Hence the failure of the left pupil to direct light stimulation must be due to a lesion in the afferent part of the

left reflex arc. It has already been seen that the lesion is neither in the retina, nor in the optic commissure, nor in the part of the visual tract posterior to the commissure; therefore it must be in the only remaining part of the afferent path, viz., in the trunk of the optic nerve. The patient then, when first seen a month ago, was recognised to be suffering from retro-bulbar neuritis on the left side. Her present condition confirms that diagnosis. She has to a considerable extent regained the capacity for sight with the left eye, though not by any means to the level of the normal standard. Central vision is, even yet, less perfect than peripheral. This is more especially seen when testing colour vision. Thus neither red nor green is recognised when she looks directly at a small test object of either colour respectively, though she answers confidently when the coloured object is moved to one or other side, the eye remaining fixed. And the ophthalmoscope shows that the effects of the lesion have travelled down the trunk of the nerve to reach the optic disc, as this now gives definite evidence of inflammation in the shape of exudation blurring its edges and partially concealing some of the retinal vessels.

The diagnosis thus being attained there remained the questions of prognosis and treatment. Concerning the former, it is certain that a considerable proportion of the patients who suffer from retro-bulbar neuritis make a complete recovery. At least they regain perfect form-vision, and of many nothing further is heard. In some cases, on the other hand, the neuritis is followed by optic atrophy, and the sight of the eye, either completely or partially, is permanently lost. Then there are other instances in which an attack of retro-bulbar neuritis is followed, perhaps after a considerable interval, by the development of disseminated sclerosis.¹ The etiology of the condition is very obscure. It sometimes appears after exposure to cold; in some cases it is associated with a history of syphilis or gout. Rheumatism seems to have in certain patients an influence in its development; but very often it is impossible, in the individual patient, to find any adequate explanation. That is the position in the present case. The girl gives no history of rheumatism, and she is in good general health. She states that she had a

¹ For an example of this see POLYCLINIC for December, 1901, p. 294.

similar but less severe attack involving the other eye about a year ago. It is probable, therefore, that she illustrates what is known to be true of some cases of retro-bulbar neuritis, namely, that it may attack one eye and then after an interval the other. There remains the question of disseminated sclerosis. That possibility must necessarily make the prognosis a somewhat guarded one. At present there are no definite evidences of that disease, though it must be noted that the knee-jerks are somewhat decided. But there is neither ankle-clonus, Babinski's sign, nystagmus, intention tremor, nor a slurred character in the speech; and at no time has there been diplopia, a temporary paralysis in the limbs or elsewhere, or any disturbance of the functions of the bladder. Beyond this it is impossible to advance. The probability is that the girl will regain her sight, but for some time she must remain under suspicion in reference to possible developments in her central nervous system. The treatment adopted when the girl first came under observation was the administration of one grain of grey powder twice a day, and a mixture containing potassium iodide and sodium salicylate.

A Case of Bi-lateral Optic Atrophy and Sixth-Nerve Paralysis.

In our last number¹ we remarked on the numerous cases presented in our consultation theatres in illustration of the manifold clinical features exhibited by patients the subjects of tabes dorsalis. During recent months there have been examined quite a number of patients whose sole complaint was of diplopia due to an ocular paralysis, and who, on critical investigation, were found to have undoubted signs of central nervous disease. In an occasional instance the patient, usually a young adult, has been discovered to be the subject of disseminated sclerosis.² But in the great majority of cases the ocular paralysis has occurred in patients of middle age, and with it there have been such evidences of tabes dorsalis as absence of the knee-jerks, Argyll-Robertson pupils, &c., &c. It has thus become a familiar doctrine that an ocular paralysis demands a complete investigation of the state of the patient's nervous apparatus. The present case continues the series in which ocular paralysis

¹ The POLYCLINIC, January, 1902, p. 24.

² See the POLYCLINIC, December, 1901, p. 295.

appears as a feature of *tabes dorsalis*, but it provides a variant in two respects. In the first place, our cases hitherto have exhibited a paralysis involving one or more branches of the third nerve. In the second place, the paralysis has been unilateral. The patient with whom we are now concerned had paralysis of the *sixth* nerve, and this was present on *both* sides. The case therefore adds two additional features of interest to our series. The most common form of ocular paralysis in *tabes dorsalis* is certainly a third-nerve paralysis on one side, though bi-lateral ptosis is not very infrequent. An example of the latter is figured in Sir Wm. Gowers' well-known volume, and an instance of it was shown at the Polyclinic in September last, though it is not quite certain that the last-mentioned was a case of *tabes dorsalis*.¹ Another noteworthy feature of the present case is the sex of the patient. She was a woman of 49 years, complaining of double vision and failure of sight. The cause of the diplopia was obvious, for the patient exhibited convergent strabismus, and could not carry either eyeball outwards beyond the middle line. Except for the paralysis of each external rectus, the movements of the eyeballs were normal. At first sight such a paralysis, with a history of failure of vision, suggested a gross intracranial lesion, with resulting double optic neuritis. But the ophthalmoscope showed that instead of optic neuritis there was primary optic atrophy, the disc on each side being unduly white, and with clean-cut edges. An ocular paralysis, and primary optic atrophy, form a combination sufficient in itself to suggest a diagnosis of *tabes dorsalis*. Each is a comparatively common event in the course of the disease, and either one or the other may precede the display of spinal symptoms. On the other hand, a gross intracranial lesion, such as a tumour, might readily involve both sixth nerves, but it could not produce primary optic atrophy unless it was situated so as to exercise pressure on the optic commissure, and in this situation it could hardly damage both sixth nerves. There remained the alternatives of a multiple lesion, or of a diagnosis of *tabes dorsalis* with early ocular symptoms. In favour of the latter were the following facts: Both pupils were distinctly small; they were unequal; the left had no light response, and

¹ See the POLYCLINIC, October, 1901, p. 179.

that of the right was only slight, and with this there was on both sides contraction of the pupil in convergence ; the knee-jerks were slight in degree and sluggish in character, though a fair measure of response was obtained by the method of " reinforcement."

The Treatment of Affections of the Cornea.

Having exhibited examples of interstitial keratitis, keratitis following a burn, and central opacity of the cornea, Mr. Marcus Gunn discussed generally the treatment of affections of the cornea. It may be laid down, he said, as a safe rule, that in all acute conditions involving the cornea primarily and solely, the treatment must embrace rest and protection of the eye, by means either of a shade or dark glasses ; the application of moist heat in the shape of fomentations, and the local use of ointment or drops containing atropine. The ointment should be made with yellow, not with white vaseline, because this latter has irritating properties. And atropine itself, not atropine sulphate, should be used, as the alkaloid dissolves in vaseline, whilst the sulphate is merely mechanically mixed with the ointment basis. The influence of atropine is beneficial in several ways. By paralysing the ciliary muscle it secures rest for the eye. The dilatation of the pupil which it causes, has the advantage of removing the mass of the iris to the periphery, and thus in the event of an ulcer penetrating the cornea at or near the centre there is probably less risk of the iris becoming engaged in the perforation. Again, the atropine ointment has a local soothing effect, and by lessening secretion diminishes the annoyance of excessive lachrymation. In no form of keratitis should cocaine be used. When photophobia is troublesome there is some temptation to forget this maxim. But it ought always to be borne in mind. Cocaine, both by contracting the blood-vessels, and by its effect on the terminal twigs of the fifth nerve, exerts a prejudicial influence on the nutrition of the corneal epithelium, and when this is already injured by inflammatory changes, the addition of cocaine may have serious results. Applied as a temporary local anæsthetic to a healthy cornea, as for example in the removal of a foreign body, or in an operation for cataract, cocaine is, of course, of the highest value. But in inflammatory

affections of the cornea it is to be avoided. Regarding the administration of grey powder in interstitial keratitis, Mr. Gunn is inclined to doubt its value, at least in the poorly-nourished children who abound in the out-patient department. These patients, as a rule, do better with cod-liver oil or syrup of iodide of iron. In resulting opacity of the cornea, the local treatment should be the use of a weak ointment (4 to 8 grains to the ounce) of yellow oxide of mercury.

DISEASES OF THE NOSE AND THROAT.

BY HERBERT TILLEY, M.D., F.R.C.S.

Friday, January 3, 1902.

Three Cases of Hoarseness.

THREE patients were shown to illustrate the importance of regarding persistent hoarseness as a symptom calling for a careful laryngoscopic examination. Temporary attacks are of course met with as the result of a more or less acute laryngitis. A more persistent hoarseness may be due to a simple chronic laryngitis, originating perhaps in an acute attack, and passing into a chronic stage under the influence of such causes as excessive use of the voice, an impure atmosphere, or the immoderate use of alcohol or tobacco. But apart from the development of hoarseness in such circumstances as these, it has to be remembered that a hoarse voice may be the expression, and is sometimes the only symptomatic expression, of structural disease in the larynx, and that this may be either the result of such general infections as syphilis or tubercle, or a local development which may or may not demand operative interference. In yet other instances the loss of voice may be due to one of the various forms of laryngeal paralysis. Failure to examine the larynx may thus not only lead to ineffective treatment, but may also cause grave errors in prognosis. A patient who is the subject of syphilis or tubercle may in this way be allowed to lose the advantage of early diagnosis and

prompt treatment; or the beginnings of malignant disease may be permitted to develop to a stage in which operative measures are practically useless, because recurrence is almost certain. It should be a clinical rule admitting no exceptions, that hoarseness persisting for any time longer than three to four weeks, is a circumstance demanding inspection by the laryngoscope.

The first patient, a man of 36 years, and a professional singer, had complained of hoarseness from two to three months. With the laryngoscope there was seen a small greyish-white tumour attached to the posterior end of the right vocal cord and extending a short distance on to the adjacent arytenoid cartilage. In phonation the right cord did not move freely to the middle line, and thus, the glottis not being closed, the voice was imperfect. Dr. Herbert Tilley remarked that in every case of laryngeal tumour it is of great moment to observe the mobility of the vocal cords. Defective mobility may mean general infiltration of the cord, and may thus, more especially in a patient who has reached middle age, suggest in the strongest possible manner that the tumour is malignant in character. At the same time it must be recognised that a chronic inflammatory growth may equally interfere with the movement of the affected cord by involving the tissues around the crico-arytenoid articulation. In the present instance, the situation of the tumour rendered it probable that the imperfect mobility of the right cord was to be explained in the manner last described. In addition, the age of the patient was not in favour of a diagnosis of malignant disease. And further, the man admitted having acquired syphilis some nine months ago. Taking these facts together, the case was diagnosed as one of syphilitic growth in the larynx, and full doses of mercury and iodide of potassium were prescribed. At the same time it was indicated that if after two or three weeks the tumour had not disappeared, it would be right to remove it by intra-laryngeal forceps. Microscopic examination might then resolve any doubt as to its nature, and further local treatment (if any) could be selected.

The second patient was a woman of 33 years. She was a board-school teacher, and her hoarseness was so extreme that she had for many weeks been unable to attend to her duties. In addition to a reddened and congested condition of the vocal cords, there was seen

projecting forwards from the inter-arytenoid space a considerable mass of a greyish colour and somewhat irregular surface. This, by its bulk, prevented the normal apposition of the vocal cords, and so explained the hoarseness from which the patient suffered. Attention was particularly drawn to the fact that the mobility of the cords was not impaired. Whilst the tumour mass mechanically prevented them coming actually into contact, they moved in towards the middle line and closed tightly on the growth in attempted phonation, and swung freely outwards as the patient took a deep inspiration. This fact alone was sufficient to exclude the diagnosis of malignant disease, as any malignant growth in this situation and approaching the size of the present tumour would certainly have caused fixation of the cords. It was thus certain that the growth was a simple or benign tumour. And its situation and characters enabled it to be recognised as an example of *pachydermia diffusa*, that is, a condition of hypertrophy of the laryngeal epithelium and submucous tissues not by any means infrequent in the inter-arytenoid region. In speaking of the causation of pachydermia, Dr. Tilley drew attention to the patient's sex and occupation, as he had found female board-school teachers to be frequent subjects of this condition. He suggested that the habit of speaking in high-pitched tones, in addressing the large classes placed under their charge, produced repeated irritation and so led to overgrowth of the mucous membrane. In the same way may be explained the development of the so-called "singer's node," a small fibrous mass at the junction of the anterior and middle thirds of one or other vocal cord. Each condition is a not infrequent cause of hoarseness in professional voice users, and each tends to improve when the voice is given a prolonged period of rest. Apart from non-physiological methods of voice production, other sources of chronic irritation, as a dusty atmosphere, excess in alcohol or tobacco, &c., may cause the development of these localised forms of chronic laryngitis.

The treatment of pachydermia in slight cases consists in rest of the voice: small, say 5 gr., doses of potassium iodide, or $\frac{1}{10}$ gr. of proto-iodide of mercury; and the application thrice weekly, and by means of a suitable syringe, of such an astringent injection as perchloride of mercury 3 grains, glycerine 15 minims, water to

1 ounce. Steam inhalations carrying acetic acid or an alcoholic solution of salicylic acid may also be employed. If the growth is of considerable size it should be removed by the forceps, and the base painted with a solution of silver nitrate (gr. 60 to 3j).

The third patient, a girl of 20 years, had only a moderate degree of hoarseness, and this varied at different times. It had, however, been present to a greater or less extent for several weeks. On examination the larynx generally appeared healthy, but in phonation it was observed that the left vocal cord did not accurately approach the middle line. Its edge presented a somewhat wavy outline and was arched, with the convexity directed outwards. These appearances indicated a paresis of the internal tensor muscle of the cord. In the present case the paresis was only unilateral, and thus the voice was not much affected, as the opposite cord in such circumstances displays a certain compensatory over-action and crosses the middle line to meet its imperfectly-acting fellow. When, as is not infrequent, the internal tensor on both sides is paretic, the aphonia is apt to be complete. Dr. Tilley spoke of the frequency with which this condition is seen preliminary to definite laryngeal changes due to tuberculosis or syphilis. It may possibly be the case that specific deposits have already taken place in the deeper tissues of the larynx, but have not yet reached a stage rendering them visible to laryngoscopic examination. Whatever be the explanation, it is certain that such a condition of the voice and vocal cords calls for a very thorough investigation of the patient's history and general health. The present case afforded a full justification of the accuracy of this remark. Dr. Hawthorne, having examined the patient, reported that there was impaired percussion and prolonged inspiration over the apex of the left lung, and that both here, and elsewhere over the chest, highly suggestive clicking râles were heard. The patient's temperature was 100·2, and she admitted the existence of a troublesome cough. There was also a marked family history of phthisis pulmonalis. The case was thus a very graphic demonstration of the importance of investigating from a broad standpoint every case of prolonged hoarseness, even though this is slight in degree and varying in severity. As far as the laryngeal condition is concerned some benefit will probably be produced by the administration of strychnine and by

inter-laryngeal faradisation, but it is obvious that the full treatment of the patient calls for measures based upon the wider diagnosis of pulmonary tuberculosis.

Case of Naso-Pharyngeal Tumour.

The boy whose case was described in our December issue (Vol. V., p. 306) was now shown subsequent to operation. There had been a considerable tumour, which presented at the left nostril, and the attachment of which could be traced backwards to the posterior ethmoidal and basi-sphenoid region. The situation of the tumour, its soft vascular character, and the rapidity of its growth, had rendered the diagnosis of sarcoma almost inevitable. It was, however, decided to give the patient the chance of operation, more particularly in view of the fact that clinical experience shows sarcomata in the naso-pharynx to be decidedly less malignant than they are in other parts of the body. After consultation, Ollier's method was selected, in the hope that it would give sufficient access to the nasal cavity to permit the passage of a ligature round the base of the tumour. An incision was therefore made over the root of the nose, the nasal bones were sawn through, and the nose drawn downwards on the face. Unfortunately, the attempt to approach the tumour in this way was not thoroughly successful. The attachment of the mass was too extensive to allow complete removal, and the very free hæmorrhage produced a risk of syncope in addition to the danger due to the entrance of blood into the trachea. It was thus necessary to stop the operation without fully attaining the desired end, for only half of the growth could be removed. Subsequently Dr. Tilley determined to attempt to remove the tumour by operation through the mouth. After the introduction of a laryngotomy tube, and the insertion of a sponge above the larynx, the soft palate was divided, and the hard palate chipped away, thus affording complete access to the nasal cavities and permitting thorough removal of the tumour. The boy has made a highly satisfactory recovery. It is intended subsequently to repair the soft palate, with the expected result that the patient will then be practically restored to health. This expectation is all the stronger as pathological examination reports the tumour to be "in no sense a sarcoma." It is found to consist of fibrous tissue with numerous large vessels, and may be named a fibro-angioma.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY JONATHAN HUTCHINSON, LL.D., F.R.S.

Lupoid Papules arranged in a Streak along the Upper Extremity.— Commencement in an Inflamed Patch at Base of Thumb-nail.

AN interesting example of a streak of chronic papules, running up from the hand almost to the shoulder, was presented in a little girl named May H., aged 8 years. The case was of much importance, because it seemed to throw some light upon the mode of development of these curious attacks. In commenting upon some similar cases I had seen in former years, I advanced the suggestion that they took their origin from a peripheral lesion and that the streak of papules was arranged along lines of lymphatic absorption.

It is not meant by this that lymphatic trunks are affected, for the changes are quite evidently in the skin itself, and when once developed they are remarkably persistent, lasting usually throughout the patient's life. Our present patient afforded remarkable confirmation of this hypothesis. A streak of red, slightly polished papules extended from the thumb-nail of the right hand, along the back of the thumb, the whole length of the radial border of the forearm, and in a slightly marked condition (little more than mere erythema) up the outer side of the upper arm. The width of the streak was nowhere more than about half an inch. Exactly one lateral half of the thumb-nail was affected and was broken up, and at the root of the nail the patch was inflamed and presented an irritable fissure. On all other parts the streak was free from irritation. The mother's history was quite definite that the disease had begun at the root of the nail and that it had gradually spread upwards. This was in May last and during warm weather. Under treatment it had almost disappeared, but during the last few weeks it had relapsed and assumed its present condition.

In commenting upon the case I said that we must carefully distinguish these streaks, attended with more or less inflammation and never congenital, from certain others which are congenital and non-inflammatory, and which are sometimes known by the name of

Bielt's bands. Of the present class of case an excellent series of illustrations are in our Museum, one of the most important of these being the arm of an adult woman, who came under our observation



Carlisle Case.

at Park Crescent a few years ago. In that case the streaks in part had assumed an eczematous type. The remarkable persistence of the papules and the smooth polished tops which they sometimes

assume has led some observers to suppose that these streaks are of the nature of lichen planus. There is probably no real relation between the two diseases, and it is more likely that, as I suggested in connection with the first case recorded, they are due to infective irritation of a tuberculous character.

In the Museum I have placed them in association with lupus, and this I believe is their correct position. One of the most remarkable examples of them occurred in a boy named Hillyer, who had patches of a peculiar form of lupus on his face.

In connection with the above case I mentioned one, the particulars of which, together with an illustration (p. 98), have been supplied to me by my friend, Dr. Ledyard, of Carlisle. This illustration is here appended. The full particulars of Dr. Ledyard's patient have been placed for reference in the Polyclinic Archives.

Case of Infantile Paralysis of Upper Extremity.

An infant, aged 1 year, was sent by Dr. Rocher, with the statement that for six months it had suffered from weakness of the right arm consequent on a fall on the face. The right upper extremity hung helpless by the side of the trunk, and all the muscles of the upper arm were atrophied, the limb in this part being simply skin and bone. The child could, however, in a feeble way, move some of its fingers, and the forearm and the hand were less wasted than the upper part. Its age precluded any precise estimation of the condition of individual muscles of the forearm. The atrophy of the deltoid and scapular muscles was absolute, and the ligaments of the shoulder being much relaxed, the head of the humerus could be freely pushed in various directions.

In connection with this case I showed the photograph from which the appended woodcut is taken (p. 100). It illustrates a precisely similar condition of things in a later stage. There was almost an exactly parallel history. The cases are examples of the essential paralysis of infancy, and the history of falls or other injuries, so frequently given, is usually of but little importance. I pointed out that the cases were remarkably similar, and that it was quite usual to find the upper muscles affected whilst some of the peripheral ones escaped. The deltoid and other shoulder muscles were not infrequently completely paralysed in patients who could use the

hand and forearm more or less well. As regards prognosis there is little hope of improvement, unless it is obtained within the first few months. Usually, as in the present case, the paralysis is on one side only.

I adverted to the fact that in these cases the paralysis appears to affect the tonicity of the ligaments themselves, and leaves the joints in a very loose condition.



Muscular Atrophy resulting from Infantile Paralysis. (Original photo.—J. H.)

*A Case illustrating the Treatment of Rodent Ulcer of the Face
by the Actual Cautery.*

I introduced a lady, Miss B., a schoolmistress, aged 52, as an example of the efficacy of the actual cautery in the treatment of rodent ulcer. She had, in the first instance, been brought to me with a rodent ulcer on the left side of her nose. Her history was that she had lost several aunts from cancer. She believed that no fewer

than three had died in middle-age of scirrhus. This was on December 27, 1895. I then used Paquelin's cautery very freely, destroying the ulcer and with it part of the left ala. Sound healing with a soft scar resulted. Three years later there was a relapse, and I again used the cautery. On October 23rd of the present year I applied the cautery for the third time. On this last occasion the recurred growth had only been noticed a few weeks and was not bigger than a pea. Thus it might be said that two cauterisations had kept the patient free from disease for six years. In venturing to contrast the results in this case with those obtained with the X-ray treatment, I said that the latter was still on its trial as regards the permanency of results. It had the advantage over the actual cautery in being painless, but then it was very tedious and very expensive. I mentioned the details of many cases under my own care in which excellent results had followed the use of the cautery. In some of these no relapse had occurred for many years, but in others repeated applications, possibly one a year, had been necessary. The patients always bore them willingly without an anæsthetic and made light of the pain. The scars produced were, as a rule, quite as thin and supple as those which follow the X-ray treatment. The cautery which I use is always Paquelin's, and I employ it very freely. There are cases of rodent ulcer so extensive as to be beyond hope of treatment in this manner, and it may be that for these the X-ray treatment will be found to have special advantages. I cannot doubt, however, that for all superficial ulcers the cautery offers a far more expeditious and quite equally satisfactory method of cure. The pain which it causes is not great, and it ceases as soon as the cauterisation is over. It is a remarkable fact that those who have had the cautery used once never flinch from it a second time. I now never excise rodent ulcers, having found that liberal cauterisation produces much more satisfactory results. The one essential is that it should be done very freely.

Remarks on Xanthoma Palpebrarum as a Symptom of Liver Disorders.

Mr. Bell, of Rochester, sent us an example of xanthoma of the eyelids in an early stage, with the statement that the diagnosis had been made with the assistance of a coloured illustration. The

patient, who was a chaplain in the Forces, kindly submitted to demonstration, and was able to give us a very intelligent account of his health. His patch was a small one, of the characteristic chamois leather texture, and placed in the characteristic position above the inner canthus of the left eye. The case afforded us the opportunity of discussing the value and meaning of xanthoma palpebrarum. Our patient said that although he had enjoyed, on the whole, good health, he had suffered very severely from sick headaches, and that he had on one occasion had an attack of transitory jaundice. His account of this attack, which was attended with pain and sickness, suggested the diagnosis of gall-bladder calculus. He did not know of the occurrence of xanthoma in any relative, but said that his wife had patches on both her eyelids. She also, like himself, had suffered much from bilious headaches.

I expressed the opinion that xanthoma patches on the eyelids were almost always the result of recurring attacks of liver disturbance. These attacks are not always recognised by the patient as of the nature of sick headache, but they are almost always attended by transitory pigmentation of the eyelids. The xanthoma consists of a fibro-fatty change, attended with hypertrophy, in the tissues of the true skin. Yellow oily globules accumulate in the cells of the part affected, and the yellow staining is of bile origin. The condition usually illustrates what the patient has gone through in past years, rather than what he has to expect. It is a retrospective symptom, and as the tendency to sick headaches usually ceases when we advance towards and past middle life, so the production of xanthelasma patches on the eyelids is seldom seen either to originate or to be aggressive in later periods. Now and then, however, it is so, and it is the precursor of a generalised xanthoma process affecting other regions of the skin. In these latter cases there is always organic disease of the liver, very usually gall-stones, and bile elements are habitually, and for years together, present in the blood. The formation of the gall-stones may, however, be accounted as almost an accidental complication, and we come, therefore, to the conclusion that the common form of xanthoma of the eyelids does not, as a rule, imply any risk of organic disease of the liver, of jaundice, or of the generalised form of the eruption. In some cases it is hereditary, and may occur in those who have not

experienced any attacks of liver disturbance. There is a family form of it in which several brothers and sisters develop these patches whilst remaining to all appearance in perfect health.

If xanthoma patches are considered as a disfigurement they may be very easily removed by excision, and they very rarely recur. The excision must, of course, take the whole thickness of the skin, and the wound should be closed with a few fine sutures.

COMMITTEE ON CLIMATE.

THE PREVALENCE OF SYPHILIS IN NATIVE RACES, Etc.

A MEETING of this Committee was held on Thursday, November 21. Amongst those who took part in the proceedings were Sir William Kynsey, Mr. Hitchins, Mr. Hutchinson, Mr. E. E. J. Simpson of Oudh, and Mr. W. E. de Korté of Cape Colony (Graaf Reinet).

The subject first brought forward was *The prevalence and severity of syphilis in tropical countries and the modifications, if any, required in its treatment*. This was brought before the Committee by reading the proof of the *Leader* published at page 271 of our December (1901) issue.

A general concurrence was expressed by all speakers that the administration of mercury is the proper treatment for syphilis, alike in the tropics as in Europe. Mr. Simpson said that in India there was still amongst the natives a widespread faith in certain vegetable remedies, and that mercury was used by them in a very hap-hazard manner and often in too large doses, and hence some prejudice as regards it. It was agreed that the hypodermic method could not be suitably carried out amongst native populations, and the statement was made that even in military practice in India it was fast declining in favour. Mr. de Korté said that he could fully confirm the statements made as to the efficiency of the grey powder pill and the absence from inconvenience in its use.

Mr. de Korté made some important statements as to the prevalence of syphilis amongst native races in South Africa. It was, he said, chiefly a non-venereal disease. It was very rare to see a

chancre on the genitals. Children were very frequently the sufferers, and it was dangerous for Europeans to entrust their children to native nurses. In children the primary sore was scarcely ever recognised, nor, indeed, did the secondary rash always claim attention. Very often the patients came under treatment for the first time when suffering from severe ulceration of the throat or some form of early tertiaries. In reply to Sir Wm. Kynsey, he said that he thought that the manifestations of the disease were of much the same character as those seen in English practice, and that the treatment should be the same. Sir William remarked that it was a very important piece of information that the primary chancre was so often unrecognised, and that the transmission was so usually non-venereal, and asked whether there could be any doubt as to the nature of the malady. The reply was that there could be none whatever. It was certainly syphilis propagated by accidental contagion. Mr. Hutchinson remarked that in English practice chancres occurring on other parts than the genitals often excited but little attention. They were by no means easy of recognition, and were not unfrequently apparently insignificant. It was, for the most part, on the genitals only that the well-known Hunterian or indurated chancre was observed.

The discussion having passed to the subject of Leprosy, Mr. de Korté stated that he had seen very little of that disease in South Africa, and he believed that it was declining. Formerly there had been a leper home at Graaf Reinet, but now all cases were sent to Robben Island. In reply to a question he said that dried and salted fish, to a certain extent, was consumed inland in South Africa, but he did not think very largely. Sir William Kynsey spoke of his experiences of the disease in Ceylon, and said that he had never known an instance of its developing in a hospital nurse or attendant. He was inclined to believe, however, that under conditions of very intimate intercourse it might be transmitted by contagion. Mr. Hutchinson remarked that it is singular that in a great majority of cases, and almost universally in all Europeans who contract the disease, there has not only been no intimate intercourse, but that the patients deny having ever seen a leper.

REVIEWS AND NOTICES OF BOOKS.

REPORTS OF THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN, vol. i., Session 1900-01. Edited by Sydney Stephenson, F.R.C.S., George Carpenter, M.D., and Theodore Fisher, M.D.

THE first volume of Reports issued by the recently-formed Society for the Study of Disease in Children affords ample justification of the existence of the Society, and gives gratifying evidence of the energetic spirit in which its work is being prosecuted. It is evident that clinical studies have largely occupied the attention of the members, and a valuable feature of the volume now before us is the number and excellence of the illustrations. We may venture to express a special word of appreciation of the coloured drawings of the fundus which accompany the exhaustive paper on Tuberculosis of the Choroid, by Dr. George Carpenter and Mr. Sydney Stephenson. We are glad to see that the discussions on the various papers and cases are well reported.

THE WAR AGAINST CONSUMPTION. By Dennis Vinrace, M.R.C.S., L.S.A. Revised by Jno. H. Vinrace, M.B., M.R.C.P. 1901 : The Century Printing Co., London.

THIS is a useful summary of the principal proceedings of last year's International Congress on the subject of Tuberculosis. It cannot of course claim the technical completeness of an official record, but it outlines in a very readable form the main current of the several papers and discussions. For those who have no time or inclination for details, it therefore offers a convenient statement of modern doctrine on the various aspects of tuberculosis. The author's aim is more popular than scientific. Possibly in one or two points his pages discuss subjects which are hardly suitable for the forum, but on the whole he has accomplished his task with both skill and discretion.

THE MEDICAL TREATMENT OF GALL-STONES. By J. H. Keay, M.A., M.D. London: Rebman, Limited, 1902.

THE main purpose of Dr. Keay's essay is to support the thesis "that the records of gall-bladder surgery during the last ten years have clearly shown that the results anticipated have not been realised, and that, unless in the most exceptional cases, the gall-bladder sufferer will derive more real and lasting benefit from hygienic and medical treatment than from operation." Before arriving at this conclusion Dr. Keay has evidently made a very careful study of his subject, and his readers, whether they subscribe to his verdict or dissent from it, cannot fail to gather from his pages a number of valuable hints in reference both to diagnosis and treatment.

TRANSACTIONS OF THE NEW HAMPSHIRE MEDICAL SOCIETY. Concord, N.H., 1901.

[] WE have the pleasure to acknowledge the courtesy which has prompted the Society to send us an account of their one hundred and tenth anniversary. The volume contains several excellent papers and discussions on professional subjects, and also some "post-prandial exercises" which reflect credit on the oratorical capacities of our New Hampshire brethren. In one of the addresses there is attributed to Franklin an effective retort to the scornful question: "What is the *use* of this or that scientific discovery?" "I do not know," said Franklin. "What is the use of a baby?" "The future alone can show."

CORRESPONDENCE AND ANSWERS.

"Mungo Park's Travels," 1799, vol. i., p. 275. Of the Mandingoes he writes:—

"The other diseases which prevail among the negroes are the Yaws, the elephantiasis, and a leprosy of the very worst kind. This last-mentioned complaint appears, at the beginning, in scurfy spots upon the different parts of the body, which finally settle upon the hands or feet, where the skin becomes withered and cracks in many places. At length, the ends of the fingers swell and ulcerate, the discharge is acrid and fetid, the nails drop off, and the bones of the fingers become carious, and separate at the joints. In this manner the disease continues to spread, frequently until the patient loses all his fingers and toes. Even the hands and feet are sometimes destroyed by this inveterate malady, to which the negroes give the name of balla jou—'incurable.'"

Of the same negroes he records, on p. 280, vol. i., that—

“The labours of the field give them pretty full employment during the rains, and in the dry season the people, who live in the vicinity of large rivers, employ themselves chiefly in fishing. The fish are taken in wicker baskets, or with small cotton nets, and are preserved by being first dried in the sun, and afterwards rubbed with stea butter to prevent them from contracting fresh moisture.”

Lieutenant William Patterson’s “Narrative of Four Journeys into the Country of the Hottentots and Caffraria in the Years One Thousand Seven Hundred and Seventy-seven, eight, and nine.” London, 1789, p. 5 (1st Journey):—

“On the 5th of October, 1777, the day before our departure, we were entertained with observing a very uncommon phenomenon, which the people ascribed to a severe north-west wind at sea. Such a prodigious number of fish were driven into Table Bay, particularly porpoises and sword-fish, that the whole bay was entirely covered with them, and apparently it might have been crossed on their backs. Near the edge of the bay the water was red with their blood, and several hundreds of the fish were driven on shore, which the people cut up for oil.”

“Fourth Journey,” p. 115. Of one tribe he writes:—

“Their huts were much superior to those of the generality of Hottentots; they were loftier and thatched with grass, and were furnished with stools made of the back bones of the grampus. Several species of fish were suspended from poles stuck into the ground. . . . The mode of living amongst these people was in the highest degree wretched, and they are apparently the dirtiest of all the Hottentot tribes. Their dress is composed of the skins of seals and jackals, the flesh of which they eat. When it happens that a grampus is cast ashore, they remove their huts to the place, and subsist upon it as long as any part of it remains; and in this manner it sometimes affords them sustenance for half a year, though in a great measure decayed and putrified by the sun. They smear their skins with the oil or brain, the odour of which is so powerful that their approach may be perceived some time before they present themselves to the sight. They carry their water in the shells of ostrich eggs and the bladders of seals, which they shoot with bows. Their arrows are the same as those of all the other Hottentots.”

Burchell’s “Travels in the interior of Southern Africa.” Longman, 1822, vol. ii., p. 580. Speaking of the Bachapins:—

“I never saw among them any symptoms of elephantiasis or other variety of leprosy, nor of any other disease of that complexion, although indubitable proofs of these dreadful maladies may be observed among all the more southern tribes.”

Vol. i., p. 79:—

“The price of provisions is, comparatively with England, exceedingly low; labour, house-rent and firewood constitute a large proportion of the expenses of living at Cape Town. Coals are here unknown, except by small quantities sometimes landed from the ships. The town is plentifully supplied with fish, of which

a great variety are caught in the surrounding sea; freshwater fish, however, is so rare that I do not recollect having seen at table any, except eels, and these were regarded as a curiosity."

Vol. i., p. 101. (Chap. iv. A Ride through Hottentot Land to the Warm Bath at Zwarteberg) :—

"Not many miles from the Baths is a small spot, called Hemel-en-aarde (Heaven and Earth), surrounded by high mountains where there is an hospital (Ziekenhuis) for those afflicted with that dreadful and incurable malady, the leprosy. This hospital is maintained at public expense, for defraying which an express tax is levied on the colonists."

Vol. i., Burchell. (Chap. xii. Journey through the Boggeveld to the Borders of the Colony.) Pp. 275, 276. August 27, 1811 :—

"At about half a mile from Gaertner's station, a boer and his family were, in the same manner, lying with their waggons and cattle. He came to us to beg we would make his quarters on our way, and stop to give some advice for his daughter who lay very ill. Accordingly, after taking leave of the hospitable German and his wife, we proceeded, and halted for half an hour at this man's waggons.

"Entering a low temporary hut formed of sticks, rushes and mats, we found the unfortunate patient lying on a bed spread upon the ground. Both she and her mother had been expecting our visit, with hopes of having some cheerful opinion of her case, or of receiving some beneficial advice. But how was I shocked the moment I beheld her, when obliged to intimate to the father that her disease was incurable; the mother appeared greatly affected, and shed tears at hearing this. I saw, too plainly to be mistaken, all the symptoms of the loathsome leprosy, and hoped that the melancholy state of the case would not have been mentioned to the poor sufferer herself. But one of the missionaries, rather ill-timedly I thought, when he heard my opinion communicated it to her, and, judging this a proper opportunity for giving some spiritual advice, knelt down by the bedside and endeavoured to console her with some reflections on the shortness of life, representing to her how little it mattered whether we lived a longer or a shorter time in this world, so as we were but prepared for entering the next. Witnessing how distressing an effect this communication had upon her and the family who were standing round, I wished that chance had not thrown me in their way to open their eyes to her helpless situation, since we could offer neither remedy nor mitigation. The father told me that about three years ago, at which time her age was only eighteen, she had been vaccinated, but without any subsequent symptom of the inoculation having succeeded. Shortly afterwards she was attacked, as he said, with the measles, and this was followed by an eruption on her arm at the part where she had been vaccinated, after which her hands and face began to put on the deforming swollen appearance which we now beheld. She was said once to have possessed some share of beauty, but every feature was now disgusting, such is the usual effect of this dreadful disease. It is well ascertained that, fortunately, it cannot be communicated but through the blood, and here, indeed, was a melancholy instance as proof of its being so communicated by the means of inoculation. What the fate of the poor young woman was after this I never had an opportunity of knowing. Finding I could be of no service I left this unhappy family with the most heartfelt commiseration for them, not less than for the ill-fated sufferer."

THE POLYCLINIC

BEING THE

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OPTIC NERVE ATROPHY AND TABES DORSALIS.

THE occurrence of primary progressive atrophy of the optic nerves is related to tabes dorsalis as a question both of diagnosis and prognosis. The exact proportion of the cases in which it presents itself is somewhat uncertain, but the percentage is certainly sufficiently large to prevent its development in an individual patient being considered in any way remarkable. That it may be an early event in the evolution of the symptoms of tabes dorsalis is quite beyond doubt. The enquiry of special diagnostic interest is whether it may be the first, and, for a longer or shorter period, the only clinical expression of that disease. It is certain that cases of primary optic atrophy, unaccompanied by other signs of disease, exist. The question is, Are these early cases of tabes dorsalis? or to define the position in other terms, Is it probable or certain that a patient with primary optic atrophy belongs to the tabes dorsalis group and is likely sooner or later to suffer from the spinal symptoms of that disease? There are adequate reasons for answering these questions in the affirmative. In the first place it has to be recognised that cases are on record showing the development of ataxia in patients who had previously become blind from optic atrophy; the interval between the two events may be a long one, possibly twenty years or more, but the accuracy of the sequence is entirely beyond ques-

tion. Secondly, there are instances in which primary optic atrophy and an ataxic gait appear almost simultaneously and advance *pari passu*. And again, optic atrophy as a prominent factor, may be associated with other conditions, slight perhaps in degree, but of a highly significant order in reference to the diagnosis of tabes dorsalis. Thus, for example, it may be found together with loss of the knee-jerks, with a history of suggestive pains in the lower limbs, with gastric crises, or with disturbance of the functions of the bladder. To a combination of any one of these events with optic nerve atrophy the diagnosis of tabes dorsalis can hardly be refused. There is scarcely more difficulty in the cases in which, though all spinal symptoms are absent, optic atrophy exists in association with an ocular paralysis or with Argyll-Robertson pupils. But if optic atrophy may thus be combined with quite obvious evidences of tabes dorsalis, and if, further, the evidences of that disease may be restricted, at least for some time, to optic atrophy and one other symptom, say, for example, absence of the knee-jerks or loss of the pupillary light response, there is an almost inevitable presumption that the cases in which optic atrophy exists as the single abnormal fact belong to the same pathological and clinical group. That presumption is strengthened by two considerations. First, that whilst primary progressive optic atrophy is a relatively frequent event in association with evidences of tabes dorsalis, it is a rare occurrence as a solitary and unexplained signal of organic nervous disease. Secondly, as already mentioned, there is the observed sequence of spinal symptoms following the atrophy after an interval possibly of many years; during that interval any such case appears to be one of simple uncomplicated atrophy, and a demonstration of its true nature only appears in the light of subsequent events. The practical issue of all this may be presented in two conclusions, namely: (1) That evidences of primary optic atrophy demand the most careful and repeated search for admitted symptoms of tabes dorsalis, and (2) that the absence of such symptoms for a time, and even for years, does not seriously qualify the diagnosis.

Turning to the prognostic significance of optic atrophy in tabes dorsalis, there are two propositions more or less confidently stated. The first is that when the disease commences with optic atrophy the spinal symptoms are apt to be both slight in degree and delayed

in development. The second is to the effect that when in the course of what may be called an ordinary case of tabes dorsalis optic atrophy occurs, the ataxia and other evidences of the spinal lesion cease to advance or even undergo retrogression. In support of the first proposition there is the undoubted evidence of individual cases of optic atrophy with long postponement of all signs showing an affection of the spinal cord. It may also be suggested as not unnatural that when the early stress of the disease falls upon the upper levels of the cerebro-spinal system the lower levels should for a time escape. But it is certainly not the case that early optic atrophy invariably means delay in the appearance of the spinal symptoms. On the contrary, cases which commence with optic atrophy may become ataxic and display other results of spinal sclerosis in the course of a few months. Instances of this kind, and the undoubted fact that the rapidity of the general clinical movement in tabes dorsalis varies in different cases within extremely wide limits, suggest the possibility that the significance of optic nerve atrophy as a guarantee of postponed spinal disturbance has been somewhat unduly exalted. The nature of the symptom it produces is such that early attention is directed to it, and therefore any interval which exists between its occurrence and the manifestation of the spinal aspects of the disease will receive abundant opportunity for exact and full measurement. But there are other possible early symptoms of tabes dorsalis which press but little on the patient's attention, as, for example, absence of the knee-jerks or Argyll-Robertson pupils. These are usually only discovered when by some chance or other the patient comes under the observation of the physician. And there is every reason to believe that either one alone, or the two in combination, may exist for long periods prior to any disturbance of gait. Even such symptoms as pains in the limbs, or imperfect action of the bladder, are often, at least in their less pronounced forms, borne by patients for months or years without taking medical advice, and the history of them is only obtained when, in consequence of the appearance of other symptoms, the patient is compelled to seek relief. In a similar fashion, the history of the ataxic patient not very infrequently includes, as a remote event, an ocular paralysis, which may either still persist, or may have long since disappeared, and which undoubtedly was the

first symptomatic result of degenerative nerve changes of the same nature as those interfering at a later date with the accurate co-ordination of the limb muscles. These experiences show that the initial symptom of tabes dorsalis may be of a different order in different cases ; that, whatever be its character, it may for long exist as a solitary clinical phenomenon ; and that whilst further symptoms may in some instances follow hard upon its heels, they may in other cases be indefinitely postponed, or possibly may never develop at all. That depreciation of vision as a result of primary optic atrophy may be the initial symptom is hardly in dispute. But, considering the prompt and certain disability thus caused, and considering also that ataxia sometimes rapidly succeeds the failure of sight, it may be doubted whether the definition of optic atrophy as an event specially prophetic of delayed spinal disturbance, has not at times been presented in terms somewhat more confident than the facts warrant.

Regarding the statement that the appearance of optic atrophy in the course of a case of tabes dorsalis means a tendency to the cessation or improvement of the spinal symptoms, it may also be remarked that this is certainly not always the case, and that in view of the well-known tendency of the disease in a certain proportion of instances to come to a standstill, examples of such a conjuncture cannot altogether be freed from the suspicion of mere coincidence.

C. O. H.

ON SUDDEN GREYNESS OF THE HAIR.

THERE is a widespread popular conviction that the entire hair of the scalp sometimes becomes grey in the course of a few hours, the change being usually attributed to the influence of acute mental distress or fear. Thus Byron makes the Prisoner of Chillon say :—

“ My hair is grey, but not with years,
Nor grew it white
In a single night,
As men's have grown from sudden fears.”

It is easy to trace a succession of facts, which, by an almost natural exaggeration, may have given rise to this creed. Prolonged

and extreme anxiety, without doubt, frequently tends to prematurely age its victims, and among its results may be a greater or less degree of blanching of the hair. A relatively rapid transformation in these circumstances may easily, under the influence of the dramatic sense, serve as a basis for the statement that the change took place "in a single night." It is fair to assume that this explanation is applicable to many reputed instances of sudden greyiness of the hair, and even the frequently quoted cases of certain historical personages are not secure beyond reasonable doubt. Is it therefore probable that the generally accepted statement regarding sudden greyiness of the hair must be dismissed as a popular exaggeration? Whilst in reference to many individual instances this question may be answered in the affirmative, it is necessary to remark that there is in the common doctrine nothing which involves the element of physiological impossibility. On the contrary, there are certain facts which go to show that it may quite well be true. In the first place it has to be remembered that a grey hair is not necessarily one that has lost its pigment. The essential change appears to be some alteration in the nutrition of the hair leading to the formation of minute bubbles of air in the substance of the shaft. A gradual atrophy of the pigment cells, no doubt, does occur in old age. But even here it would seem that the new fact which causes the hair to lose its colour phenomenon is the appearance of air globules in its tissue. However this new fact is to be explained, there is no doubt that it may be of rapid development, and that it may be determined by nervous influences. There are many instances on record of the sudden appearance of patches of grey hair following mental shock or distress. Such patches may appear on the scalp, eyebrows, or other parts. When once produced they often remain unchanged for years, or even throughout the remainder of life. It is, however, possible for such hairs to regain their coloration, and grey hairs which have appeared in the scalp during attacks of neuralgia have actually been observed, on subsidence of the pain, to return to their former appearance. When it is once realised that the immediate factor in the production of greyiness is the development of small bells of air in the hair substance, and that this change may be a rapid, perhaps an instantaneous one, there is no difficulty in allowing the possibility or even probability of a complete and, perhaps, an

equally rapid restoration. The way is thus open for an explanation both of reputed cases of complete greyness occurring in the course of a few hours, and also of instances of varying degrees of greyness in the same individual during comparatively narrow intervals of time. But it is possible to go still further. May it not be the case that rapid or sudden greyness is the usual event as regards individual hairs? Certainly it is no infrequent experience to discover a completely grey hair to-day where none was noticed yesterday. And similarly, when in any particular area the degree of greyness varies from time to time, the explanation, we suggest, is to be found, not in the gradual and alternate fading and deepening of the colour of all the hairs, but in the appearance or disappearance, as the case may be, of the character of fully developed greyness in a greater or less number of individual hairs, the others remaining without change. No doubt in one and the same hair parts which are quite grey may be found associated with other parts that retain their usual coloured appearance. But an intermediate state between normal coloration and perfect greyness is not, we think, common. These facts seem to justify the suggestion that, so far as each individual hair is concerned, the development of greyness is a sudden event. This view is quite consistent with the fact that the hair of the scalp as a whole usually turns grey very gradually. The two positions are at once reconciled by the supposition that the sudden change affects different individual hairs, not on the same, but on successive dates. If this is a correct statement of the usual course of events, the alleged instances of sudden greyness of the whole scalp offer no very serious departure from the normal. Their only peculiarity is to be found in the number of hairs affected on one and the same date. So long as greyness is taken to mean actual loss of pigment, its sudden development over the whole scalp, or indeed in the individual hair, seems incredible. But in view of the known explanation of the immediate cause of greyness, of the admitted fact that grey patches may develop suddenly under nervous influences, and of the suggestion that sudden greyness is the physiological time-movement for the individual hair, the evidence, so far from excluding the possibility of sudden greyness of the whole scalp, renders such an event not improbable. Of course, individual instances must be established by competent testimony, and this is

usually lacking. But there is no *a priori* reason for dismissing such cases as mere examples of over-statement arising from a popular love of the marvellous.

A single remark on the general physiological significance of the above facts may here be added. The change in the hair structure which leads to greyness is produced, without doubt, by some alteration in the nervous control of the hair tissue. The suddenness of the change, which in certain instances is not in dispute, must be taken to exclude the possibility that it is caused through the agency of the blood-vessels, and by a consequent modification of the nutritive supply. It must therefore be due to an influence acting directly through the nervous system. The circumstances thus offer a very impressive demonstration of the immediate and universal sway exercised by that system over the nutritive processes of the body. Considering that the tissues are constituent parts of one organic whole, that their individual growth and reproduction are dependent largely on their nutrition, and that these activities are conducted, not selfishly, but in subordination to a common end, such nutritive control is an obvious necessity of the position. The failure of the direction and stimulus of the nervous system over tissue nutrition is made manifest in various diseased processes, and more particularly in those grouped under the term trophic lesions. Greyness of the hair can hardly be called a disease, but its occurrence as a direct consequence of nerve disturbance has special interest as showing that even tissues most remote from the central source of nerve power, and free histologically from nerve elements, are not beyond the authority which binds the various parts of the body into an organised and harmonic unity.

C. O. H.

GRAVES' DISEASE AND RHEUMATISM.

IN any clinical enquiries regarding cases of Graves' disease it were well to keep in mind the alleged relationship of the disease to rheumatism. There can be no doubt that a certain number of the patients have either a personal or family history of rheumatism,

and a definite history of rheumatic fever has been traced on good authority in 11 per cent. of a lengthy series of cases. Allowing something for coincidence, there must here be a balance which can hardly be explained away. Every now and then a case is recorded in which Graves' disease is associated with an organic cardiac murmur, and pericarditis has also been observed. The suggestion has been advanced that the tachycardia which is a feature of the disease, may produce a structural valvular lesion, but this will hardly commend itself to the general judgment. In the great majority of cases the cardiac murmurs which are so common in Graves' disease are doubtless functional, but there are instances of the disease in association with organic lesions of the heart, and these, and the other suggestions of rheumatism met with in investigating the histories of patients, make it desirable that a possible connection between the two conditions should be remembered. A case recently under observation may be briefly quoted in support of this statement. With a distinct history of rheumatic fever and evidences of mitral disease, it was observed that the pulse, though ranging at times as high as 140 per minute, was always perfectly regular, and was thus quite unlike the condition met with when mitral disease, by causing cardiac failure, produces a rapid and irregularly acting heart. Subsequently, the patient developed exophthalmos, enlargement of the thyroid, and other symptoms which placed the diagnosis entirely beyond doubt. The course of events in this instance emphasises the importance of making each case of Graves' disease the subject of careful scrutiny in reference to any possible association with rheumatism.

C. O. H.

CURIOSITAS enquires whether syphilis is alluded to in Don Quixote. He will find the following in Chapter XXII. In the Don's conversation with the Scholar the following is put into the mouth of the latter: "Virgil (Polydore), for instance, forgot to tell us who was the first in the world that caught a cold, and *who was first anointed for the French disease*." From this expression we may gather that Cervantes not only knew of the malady but that inunction was in his circle the common remedy for it. The second part of Don Quixote, in which this passage occurs, was published in 1615—more than a century after the introduction of Syphilis into Europe. The fact that the disease is thus openly mentioned by such a writer as Cervantes adds weight to the circumstance that neither "Boccaccio" nor Chaucer allude to it. From their absolute silence we may safely infer that it did not exist in their time.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON THE TREATMENT OF SOME OF THE MORE SERIOUS INJURIES OF THE EYE.

BY HENRY POWER, F.R.C.S.

[*Abstract.*]

MR. POWER'S lecture was largely directed to a justification of the proposition that the prognosis of diseases and injuries of the eye is often a less gloomy one than the circumstances at first seem to suggest. He remarked that patients suffering from these conditions are almost invariably fearful of becoming blind, and that consequently they incline to be seriously depressed. It is therefore of much importance, even from the point of view of successful treatment, to avoid any statement which will add to this natural anxiety, and to preserve for the patient, to the utmost possible extent, the beneficial and cheering influences of hope. Thus in giving a prognosis, whilst exaggerated expectations are not to be encouraged, it is wise to dwell on the most cheerful prospects which the circumstances allow, even though these may appear decidedly uncertain and somewhat remote. Mr. Power proceeded to illustrate these statements by relating various cases which had come under his own observation. The first was that of a cabman in whom, as the result of an accident, the left eyeball was burst open, the vitreous, choroid, and even the retina, protruding from a large irregular wound in the lower and outer part of the sclerotic. In ordinary circumstances the eye would have been removed. But as the patient had lost the other eye some time previously, it was decided to give him the chance, small though it seemed, of enjoying some

measure of vision. After replacing the various parts as far as possible, therefore, the edges of the wound were approximated by sutures, and the torn edges of the conjunctiva were similarly united. Healing took place rapidly, and the patient regained useful vision to the extent that he was quite able to get about without assistance, and even, though not perhaps with perfect safety, to drive his cab. Another illustration was afforded by the case of a distinguished musician, who, already blind in one eye, had the misfortune to be struck on his healthy eye by a tennis ball travelling at a high rate of speed. He instantly became quite blind, and examination showed the presence of a considerable amount of blood in the vitreous. The patient was naturally profoundly depressed. He was, however, told that there was an appreciable chance that the blood would become absorbed, and that he might largely, or even entirely, regain the use of his eye. Cheered by this statement he remained quiet in bed for some three weeks, being allowed to lie on one or other side, but not on his back. This latter restriction was enforced in order that any deposit remaining in the vitreous might be fixed, not over the yellow spot area, but in the lateral region, where its power of limiting vision would be relatively immaterial. After three weeks in darkness the patient recognised the light of a candle when this was brought into the room, and in the end he made so complete a recovery that he was able for many years to discharge his duties as college organist at one of the English universities.

Other illustrations of injuries involving the contents of the globe were quoted from Mr. Power's experiences of gun-shot wounds. It was urged that each case in this class should receive careful consideration, and that the surgeon should not, as a matter of routine, proceed to remove the eyeball. The patient should at least have the chance of retaining the eye, unless there are symptoms distinctly indicating that such a policy is fraught with danger. Of course there are cases of serious injury where no course other than removal is open to the surgeon. But, on the other hand, instances have occurred in which shot have passed right through the eyeball and yet the patient has regained a large measure of vision. Other examples of injuries from gun-shot wounds, with only temporary loss of sight, were also narrated.

In illustration of the difficulties in regard to treatment which sometimes attend injuries to the eyeball, the two following cases were related:—The first was that of a young man who was struck on the inner side of the orbit by a bullet. There was no immediate loss of sight, but in the course of a few weeks an aneurism developed at the site of injury. Various opinions were expressed as to the best method of treating this. By some it was proposed to cut down on the aneurism, others advocated sustained pressure on the carotid, and yet again it was advised to tie the carotid. Before the decision had been taken the patient had a violent attack of epistaxis, and the carotid was then ligatured. This was followed by cure of the aneurism, but the patient became almost blind in the affected eye. In the second case, as the result of an explosion of hydrogen, a small angular fragment of glass was driven into the eyeball and remained fixed between the iris and the anterior capsule of the crystalline lens. The vision of the eye, however, remained fairly good. In the course of twelve months or so the patient wished to go to Australia, and the question was raised whether an attempt should be made to extract the glass. After some discussion the attempt was made, and the glass was removed, but the sight of the injured eye gradually failed and ultimately was completely lost.

Another group of cases discussed were those in which considerable damage is inflicted on the conjunctiva and cornea. One of these was that of a student who, as the result of an explosion of fulminate of silver, had each cornea completely covered by an opaque layer of fine dust. In view of the fact that the minute particles of pigment inserted in tattooing a corneal nebula are often rapidly removed, a hopeful prognosis was given. The future justified this view, for in the course of eight or ten weeks the appearance of the eyes was perfectly normal, and the sight was unimpaired. In a second case the patient received what looked like a most severe burn of the cornea from a heated curling tongs. There was much pain and swelling, and a broad opaque band right across the cornea. Mr. Power saw the patient immediately after the accident and was inclined to take a very serious view of the probable consequences. Yet in less than twenty-four hours the cornea had, under the influence of cocaine and a cooling lotion,

become completely clear. Somewhat similar escapes are occasionally met with after a drop of molten metal has fallen into the eye. The metal spreads out as a thin layer which can be readily removed, and the cornea is found uninjured, or with no more serious lesion than an abrasion of its epithelium. In injuries by chemical escharotics the effects are much more grave. This is especially true of quicklime, which generally leads to complete loss of the eye. Alkalies, as potash and soda, and the strong mineral acids, are also very dangerous. In conclusion, Mr. Power gave some illustrations of mistaken diagnoses, and related some further exceptional cases of recovery in spite of unpromising conditions.

ON A CASE OF ACHONDROPLASIA.

BY JAMES CANTLIE, M.B., F.R.C.S.

[*Abstract.*]

THE patient, who is figured in the accompanying illustrations, was demonstrated by Mr. Cantlie on January 8, 1902, and it is to him we are indebted for the photographs. The child, a girl aged 13 years, is, as is readily seen, of stunted growth—a condition made all the more conspicuous by placing her in contrast with a healthy, well-grown girl of normal development. The defective growth is mainly manifest in the limbs. Seated side by side the two girls appear to be about the same height, but the disparity is great when they assume the erect posture, and the difference is obviously due to the shortness of the patient's lower limbs. Similarly the upper limbs are greatly wanting in length, the tips of the fingers, as the limbs hang by the sides, hardly reaching below the iliac crests. The head appears relatively large, and there are other less prominent peculiarities, but it is the defective elongation of the limbs, associated with a trunk of approximately normal size, that gives to the patient her special clinical character.

The case is one of the rare group now known under the name *Achondroplasia*, and formerly spoken of, sometimes as foetal rickets,

sometimes as foetal cretinism. That it is not the same disease as rickets is tolerably certain. With cretinism it may possibly have some relationship, but in so far as the pathological changes in the two conditions correspond, they occur at different ages,



Mr. Cantlie's case of Achondroplasia.

and broadly the two are differentiated clinically by the absence from cases of achondroplasia of the mental defects which characterise the cretin. Thus Mr. Cantlie's patient, though helpless in many particulars because of the ill-development of her limbs, is in every

respect a very intelligent girl, and her facial expression and general bearing are far removed from the unintelligent appearance and mental dulness associated with cretinism.

As a pathological condition achondroplasia is an arrested develop-



Mr. Cantlie's case of Achondroplasia.

ment in certain parts of the bony skeleton. The parts affected are those which are normally ossified in cartilage during the earlier months of foetal life. Bones resulting from ossification in membrane are formed as usual, and the same is true of those which,

formed in cartilage, remain mainly or entirely cartilaginous until after the sixth month or so of foetal life. But the parts which are ossified in cartilage in early foetal life are stunted in their development, as if from premature arrest of the ossifying process. This defect applies to the long bones of the limbs, the ribs, pelvis, and greater part of the base of the skull.

The arrested development of the shafts of the long bones explains the shortness of the extremities. The arrest involves not only the large bones in the proximal parts of the limbs, but also those of the metacarpus, metatarsus, and phalanges. The short, stunted character of the fingers is seen in the first photograph, which also shows, what has been figured in other cases, namely, a divergence of the digits, especially marked between the middle and ring fingers.

The condition of the lower limbs gives rise to a peculiar waddling gait, and there is marked lordosis in the lumbar region. There is free movement of all the joints, except the elbows, where it is only possible to extend the forearms to an angle of 130° . This limitation of the ability to extend the forearms has also been observed in other cases.

There are two features in the limb bones which suggest, at first sight, a similarity to rickets. The one is a curvature of the shafts, the other a prominence of the terminal epiphyses. In Mr. Cantlie's patient the curvature is best seen in the tibiae, which are bent so as to present a convexity backwards. It has, however, been shown that this bending does not depend on any softness of the bones; on the contrary, the bones are quite firm and rigid. Similarly, there is no actual enlargement of the terminal epiphyses. The knobbed appearance of these is explained by relative smallness of the shafts. In the same way, the suggestion of beading on the anterior extremities of the ribs is misleading, for this does not depend, as in rickets, on cartilaginous overgrowth. It is rather due, either to a firm ring of osseous tissue, or to a prominence caused by the manner in which the shortened osseous ribs are united to the relatively long costal cartilages.

The restriction of the developmental defect characteristic of achondroplasia to bones formed by ossification in cartilage at an early date, has necessarily peculiar effects upon the shape of the

skull. The flat bones forming the roof and sides of the skull are ossified in membrane, and these have their normal measure of development. Similarly, the base in front of the sphenoid, though ossified in cartilage, is ossified at a comparatively late date, and it reaches its usual proportions. But in the posterior part of the base the process of ossification in cartilage is a relatively early event, and hence in achondroplasia this part of the skull is narrowed and shortened. As a consequence, there is considerable dislocation of the corresponding parts of the brain, and to compensate for the lessened accommodation in the deeper parts of the cranium the vault undergoes expansion. Hence the fontanelles are apt to be abnormally large, and the sagittal and coronal sutures to remain more or less widely open; and for the same reason the frontal region tends to be prominent. The effect of these conditions is to make the head appear unduly large, and to give a dwarfed appearance to the face. Another feature in the physiognomy is a depression of the bridge of the nose, which may be due to the defective elongation of the base of the skull.

In most instances, it would appear, that the fœtus when the subject of achondroplasia either dies *in utero* or shortly after birth. Only a few patients have grown into childhood. Records of some of these may be found in recent volumes of the *Clinical Society's Transactions*. One of the most complete descriptions of the disease is that given by Dr. Johnson Symington and Dr. Henry Alexis Thomson in vol. iv. of the *Laboratory Reports of the Royal College of Physicians of Edinburgh*.

THIRTY YEARS' WAR AGAINST LUNACY.

BY THOS. CLAYE SHAW, M.D., F.R.C.P.

[*Abstract.*]

AFTER a brief sketch of the policy and organisation of the Metropolitan Asylums prior to 1870, Dr. Shaw traced in detail the changes brought about by the constitution in that year of the Metropolitan Asylums Board, and by the transference, in 1899, of

the administration of the Asylums from the jurisdiction of the Magistrates to that of the County Councils. He paid a tribute both to the medical and lay authorities of the earlier period, who, in spite of the ineffective organisation and the prevailing erroneous views as to the nature of insanity, managed to secure for the patients under their charge a large measure of careful, kindly, and by no means unsuccessful, treatment. The definite advance of recent years is to be attributed to a recognition of the truth that insanity is a disease to be studied on the same lines as disease in general, that asylums are essentially hospitals, and that their construction and management must consequently be dominated by medical considerations. The movement to this position was rendered possible, largely as a result of the teaching of Dr. Hughlings Jackson, which, having modified the medical attitude in relation to insanity, has indirectly also affected the general public. Dr. Shaw then proceeded to give an account of the improvements in the construction and control of asylums which have been introduced in recent years. He alluded also to the better organisation of the medical staff, to the systematic and clinical teaching of insanity, and to the special work which is being prosecuted in the domain of pathology. Without being able to claim any very striking results in regard to treatment as an outcome of these and other agencies, he expressed a firm conviction that progress, if slow, was certainly sure, and that the work is moving in the right direction. In asylum construction he advocated specialisation in providing ward accommodation in order to secure the separation of acute from chronic cases, and the isolation of patients suffering from phthisis pulmonalis. In reference to further advances Dr. Shaw pointed to our ignorance of the causation of insanity in its various forms as a serious hindrance. He insisted on the close connection between the study of neurology and insanity, and regretted the practical separation at present existing between the two departments. The institution of clinics where the combination of mental symptoms with various forms of organic nervous disease could be studied, would be a distinct advantage as regards both research and clinical instruction. Another proposal suggested was the establishment in London of a lunatic hospital for acute cases, the hospital to have a visiting staff of neurologists, surgeons,

and specialists in the various departments; to be under the control of a public body such as the County Council; and to be fully equipped with the necessary laboratories and scientific apparatus. Reference was also made to the possible extension of surgical methods in the treatment of certain cases of insanity. In support of this the experience of the advantage of operations for the relief of intracranial pressure in general paralysis of the insane was quoted, and it was argued that in delusional insanity the existence of a definite delusion or hallucination was probably a sign of local affection of the corresponding sense area in the brain, which, on the failure of general treatment, it was legitimate for the surgeon to explore. The lecture also included a discussion of the range of usefulness of the Weir-Mitchell methods and of hypnotism in the treatment of insanity, and a criticism of the forms of registering asylum statistics.

ON STRICTURE—URINARY FISTULA—FALSE ROUTES OR PASSAGES.

BY REGINALD HARRISON, F.R.C.S.

[*Abstract.*]

MR. REGINALD HARRISON lectured on these subjects and handed round three diagrams illustrating them.

The first diagram represented a very contracted stricture in the deep urethra, following a partial rupture of the canal, with nine urinary fistulæ in various directions, and through which the whole of the urine had been passed. Mr. Harrison advocated in instances of this kind the combination of internal with external urethrotomy, and free bladder drainage, by the introduction of a large drainage tube, to secure the ready escape of the urine until such time as all the fistulæ had closed by reason of not a drop of urine passing into them. This process had been rapidly effectual in the case illustrated by the diagram.

The second diagram illustrated an obliterated urethra immediately behind the bulb, and a single perinæal urinary fistula through

which the whole of the urine escaped at the will of the patient, as in ordinary micturition. This case was one where the continuity of the urethra had been restored partly by perforating the obstructed portion, about one-third of an inch in length, and retaining a small metal catheter for three days. Then a Maisonneuve's urethrotome was introduced, and the new portion of the canal opened by the cutting blade until a No. 26 French or 15 English gauge could be readily passed throughout the whole length of the urethra. A full-sized catheter was retained for three days and then finally withdrawn, and the occasional passing of a full-sized steel sound substituted. The perinæal wound gradually closed. The parts have now remained sound for two years, and urination is normal under the occasional passage of a bougie. This result cannot always be secured, and Mr. Harrison referred to some cases in which the new passage was by reason of its cicatricial character unworkable, and the original fistula had to be reverted to for the purpose of urination. The plan of restoration described has, however, been occasionally found to answer well and was worth a trial when the conditions are favourable.

The third diagram represented a false passage where the point of a catheter had been made to leave the urethra immediately in front of a stricture in the membranous portion, and had reached the bladder by penetrating and almost undermining the floor of a normal prostate. The accident happened at sea under non-professional hands. From the examination made after death there could be no doubt that this false route had been utilised for the normal canal during something like three months. The patient's death appeared to have been caused by chronic suppurative nephritis. Mr. Harrison mentioned some other cases of a somewhat similar nature, including two which had been communicated to him by Mr. Cadge, of Norwich. Cases of this kind were worth remembering, and indicated the importance of using the finger in the rectum where any doubt existed as to the position of the instrument. Instances were mentioned where the natural passage had been restored, either by dilatation or urethrotomy, and no harm had resulted from the accident.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY JAMES TAYLOR, M.D., F.R.C.P.

Tuesday, January 28, 1902.

Epilepsy and Intracranial Tumours.

THE facts of this case enforced an important clinical lesson, viz., convulsive attacks having all the characters of epilepsy may depend on a definite organic lesion, such, for example, as a tumour of the brain. There is in such cases an obvious risk of giving an encouraging prognosis on the basis of a diagnosis of epilepsy and finding at a later date that the case is really one of tumour. Two circumstances combine to heighten this risk. First, the interval between the commencement of the quasi-epileptic seizures and the emergence of decided evidences of tumour may be a very long one—perhaps several years. Secondly, the fits are often conspicuously held in check by bromides, and the treatment for a time thus appears to justify both the diagnosis and prognosis. These considerations emphasise the importance of scrutinising very carefully all the features of a case before concluding that it is one of “idiopathic” epilepsy. This is all the more necessary when the attacks commence, not in childhood or adolescence, but after adult age has been attained. The entire absence of any evidence of family predisposition to epilepsy is another circumstance which suggests an additional claim for more than usually careful investigation. Neglect of these suggestions will every now and then carry the penalty of a serious error in prognosis. The case which was confidently labelled as epilepsy and was offered a fair prospect of complete recovery, will, by its subsequent course, proclaim itself to be one of tumour of the brain, with, of course, great disappointment to the patient and his friends and considerable discredit to the physician.

The patient presented in illustration of these statements was a man of 23 years. His history was one of good health until between two or three years ago, when he began to suffer from "fits." Some of these were described as severe convulsive attacks, whilst in others there was merely momentary loss of consciousness. Thus at the outset of the investigation there was a strong suggestion of epilepsy, with seizures both of the *grand mal* and the *petit mal* variety. There were, however, one or two circumstances which enforced caution. In the first place, the patient complained that at various times he had had really severe headache, which, from his statements, appeared to be something much more serious than the slight headache that not infrequently follows an epileptic fit. Secondly, on some occasions the headache had been attended by vomiting. Thirdly, his mental characteristics had completely changed, so that from a smart active man he had been transformed into a somewhat lethargic individual with little or no capacity for initiative. In addition, it may be noted that the family history was free from all trace of neurotic tendencies. None of these circumstances is altogether irreconcilable with a diagnosis of epilepsy, but they were regarded as notes of warning, and the patient was taken into hospital for the purpose of more systematic and continuous observation—epilepsy with mental degeneration, general paralysis, and tumour, being among the possible diagnoses. Whilst in hospital he was treated with mercury and potassium iodide (though there were no indications of specific disease), and under these his headaches largely ceased, and the frequency of the fits considerably diminished. On the other hand, a rather curious defect of speech developed, the patient in reading or speaking repeatedly dropping a syllable. And, of still more definite significance, slight optic neuritis appeared in each eye, with some hæmorrhage in the right fundus. To these there had more recently been added a degree of paresis of the right lower face.

In view of these facts there can be no reasonable doubt that the patient is the subject of a tumour of the brain, and that the "fits," which at first appeared to be those of epilepsy, were the early consequences of this new growth. The position of the tumour is to some extent a matter of conjecture. The disturbance of speech suggests that there is some, but not a serious, interference with

Broca's convolution. Tumours of the pre-frontal lobe are not infrequently associated with changes in the patient's mental disposition, and perhaps more particularly with some such failure of spontaneity as this patient exhibited. Taking these two facts together, a probable diagnosis of tumour of the left pre-frontal lobe leading to disturbance of the speech centre may be hazarded. The paresis of the right face may be used to support such a theory.

As bearing on the diagnosis may be noted the condition of the knee-jerks. These were marked, and possibly somewhat exaggerated. It is true that both in tumours of the cerebellum and also in tumours affecting the pre-frontal region the knee-jerks may be absent. But this is by no means invariably the case. Indeed, in cerebellar growths the knee-jerks may be exaggerated. Thus while the conspicuous response here cannot be urged in support of a diagnosis of pre-frontal tumour, it certainly does not exclude that diagnosis.

With regard to the suggestion of operation, it was urged that the indications were against it. The headache, vomiting, fits, and optic neuritis had all either diminished or ceased to advance, thus justifying the inference that the tumour if growing at all was doing so very slowly. The speech defect remains *in statu quo*, but as any operation for the removal of the tumour would almost certainly produce complete aphasia, it was impossible to advise operation on this ground.

To further illustrate the statement that what appears to be epilepsy may be an early exhibition of structural disease, Dr. Taylor quoted the case of a signalman who, four years ago, suddenly began to suffer from attacks of convulsions and unconsciousness, and who quite recently developed severe headache and double optic neuritis. In this patient the bromide treatment produced marked benefit, extending the interval between the fits to a period of six months or so. Yet the diagnosis proved to be one, not of epilepsy, but of cerebral tumour.

A Case of Epilepsy.

In this patient the diagnosis of idiopathic epilepsy appeared to be justified. There were none of the circumstances mentioned in the case above related to warrant a suspicion of structural disease,

and one fact in the history was in direct opposition to such a suspicion. This was the statement that the epileptic seizures had at first been of a very mild character, and that they had gradually increased in severity. In convulsive seizures dependent on a neoplasm the fits are usually decided and severe from the outset. At first the patient merely had attacks of tremor affecting the hands. Then he began to have occasional more severe and widely spread convulsions attended with loss of consciousness, involuntary micturition, etc., and now the attacks of *petit mal* are frequent, and there are at times typical convulsive epileptic fits. The existence of the two forms of epileptic seizures is a feature of the case which makes the prospects of successful treatment less promising. It is well known that the minor attacks are less responsive to bromides than are the convulsive fits. Zinc bromide has, however, some value in the former, and in the present case 2 to 3 grains of that salt may therefore be combined with each dose of 15 grains of sodium bromide, and small doses of arsenic and nux vomica may be added. Dr. Taylor expressed himself as disposed to take an optimistic view of the treatment of epilepsy by bromides. Given in suitable doses he seldom finds any considerable degree of mental or bodily depression produced, more especially if the sodium salt is used, and is prescribed with tonic doses of nux vomica. Regarding the dose of the bromide, the right policy is to find out the minimum amount sufficient to check the attacks, and to persevere with this steadily and continuously. Occasionally the dose should be reduced as an experimental measure, with a view to determine whether a smaller dose is sufficient to hold the disease in check.

Post-Diphtheritic Paralysis in an Adult.

The patient was a man of 40 years. He had an attack of diphtheria early in October, 1901. He was treated by antitoxin, and made a good recovery. Shortly afterwards, however, he found that he was unable to read, though his sight for distant objects remained good. This obviously meant loss of the power of accommodation due to paralysis of the ciliary muscle. After some six weeks he regained the power of near vision, but at the same time he began to experience some difficulty in walking. Though in this respect he

has improved, there is still slight unsteadiness of gait, and the knee-jerks are absent. The history of course suggests the diagnosis, and this is confirmed by the distribution of the paralysis. The ciliary muscle and the lower limbs are two of the usual sites of post-diphtheritic paralysis. But even more frequent is it to find the soft palate paralysed. Indeed, this is usually the earliest, and it may be the only part affected. Thus, one of the noteworthy features of the present case is the absence of all history of affection of the palate. Another is the long postponement of the paralysis of the lower limbs. The usual course of events is for the patient to suffer from regurgitation of fluids through the nose, due to imperfect movement of the soft palate, and then, if further paralysis develops at all—whether of the ciliary muscle or the lower limbs—it does so without much delay. But in the present instance the paralysis of accommodation extended over six weeks, and only when it disappeared did the difficulty in walking ensue. The age of the patient is also worthy of remark. Post-diphtheritic paralysis is comparatively rare in adults, whereas in children it is not infrequent. The prognosis generally is good, and this is even more true of the disease in adults than in children. In the latter there is some risk of syncope, and therefore it is imperative that treatment shall include rest in bed. Perhaps such risk cannot be absolutely dismissed in those of mature age, but it is certainly at a minimum. The present patient has not been able to rest, and under the influence of strychnine he is making a good recovery.

MEDICAL CASES.

BY WM. EWART, M.D., F.R.C.P.

Tuesday, February 4, 1902.

A Case of Paraplegia.

THIS case had the very satisfactory feature that the patient had almost completely recovered the use of his limbs. He still had some degree of hesitancy in his gait, but whereas a few weeks ago he was confined to bed with paralysis of his lower limbs and loss of

control over the bladder and rectum, he is now able to walk about without assistance, and has entirely regained command of the functions of micturition and defecation. A further demonstration of the efficient restoration of the nervous mechanisms to a normal state is afforded by the return of the knee-jerks, which, in the stage of paralysis, had been entirely lost. It is a matter of constant experience that the knee-jerk frequently shows itself to be a very delicate index of the state of the nervous system. Its loss is often the earliest sign of the operation of influences prejudicial to the normal function and structural integrity of the cerebro-spinal apparatus. Witness, for example, its early disappearance in the majority of the cases of *tabes dorsalis*. The same position is also illustrated by the absence of the knee-jerk in many cases of diabetes, in which disease such absence may be almost the sole evidence of peripheral nerve degeneration. A parallel statement may be made about diphtheria. Patients who have passed through recent attacks of diphtheria may be found to have lost their knee-jerks even though they have had no obvious post-diphtheritic paralysis. And in those in whom there has been a definite exhibition of such paralysis affecting the lower limbs, it is invariably found that the restoration of the knee-jerk is only accomplished some considerable time after the power of walking has been regained. Hence, in all circumstances involving loss of the knee-jerk, the return of the jerk to a condition of healthy vigour is to be counted amongst the most convincing proofs of restored nervous structure and function. In the present case of paraplegia, therefore, the state of the knee-jerks, added to the other evidences of improvement, is to be interpreted as a sign that the lesion in the nervous system—whatever may have been its nature—has not produced any definite organic changes. It is difficult or impossible to be quite sure of the exact cause of the paraplegia. The patient, a man of 29 years, and entirely free from all history or evidence of syphilis, had been in his usual good health when he was vaccinated on December 14, 1901. A week later he began to complain of dull pain in his back and lower limbs, with headache, and pains behind the eyes. In the course of a day or two he became completely prostrated; his temperature rose to 103°F.; and he lost power over his lower limbs, with incontinence of *fæces* and retention of urine. It had

been suggested that the case was one of influenza, and the early febrile disturbance—accompanied as it was by appreciable mental dulness and loss of memory—the severe character of the paralysis at the outset, and the prompt evidences of improvement, may reasonably be advanced in support of that diagnosis. Any gross organic lesion, such, for example, as a transverse myelitis, need hardly be considered in view of the early and complete convalescence. Another suggestion had been that the paraplegia is possibly to be attributed to the vaccination. There is little or nothing to be advanced in support of this beyond the time relation of the two events, and the fact that paraplegia is noted among the rare complications of small-pox. Regarding the portion of the nervous system involved, it seems tolerably certain that the lesion must have been a central one. The absence of pain and tenderness from the limbs, the rapid development of complete paralysis, the fact that the bladder and rectum were involved, and the prompt recovery, negative the idea of a peripheral neuritis. The probability would appear to be that some transient toxic influence affecting more or less the whole of the cerebro-spinal axis, acted with special virulence on the grey matter in the lower part of the cord, and that as an effect of this, whilst there was no interruption of sensory conduction (for the paralysed limbs were at no time anæsthetic), the normal motor control of the lower limbs and of the bladder and rectum was temporarily suspended.

An Error in Diagnosis.

The patient, a man of 26 years, now in good health, had a few months ago been in a very debilitated and feeble condition. He was at that time troubled with dyspeptic symptoms, had some pain in the back, and gave rather severe evidences of general malnutrition. In addition he had a peculiar “brassy” cough, and this had given rise to a suspicion of aneurism on the basis of the well-known clinical facts—(1) that a deeply seated aneurism springing from the descending part of the aortic arch may, by interfering with the left recurrent laryngeal nerve, lead to a cough, often described as “brassy,” and (2) that such a cough may, at least for a time, be the only evidence of thoracic aneurism. With a view to test the

accuracy of this diagnosis, the patient had been examined by the Röntgen rays, and the operator had detected the presence of a "bulging" in the descending part of the aortic arch. When the patient came under systematic observation the diagnosis of aneurism was subjected to careful review. It was evident that the general malnutrition could be explained as a consequence of the dyspepsia, and the age of the patient was hardly in favour of aneurism. Again, though he had at times a cough with peculiar features, he was quite able to produce a cough of normal character, and there was no appreciable defect in the movements of the vocal cords. And further, there was an entire absence of the usual signs and symptoms of thoracic aneurism. It was therefore decided to dismiss the diagnosis of aneurism and to treat the man by careful feeding, by exercises, and by massage. Under these measures the evidences of dyspepsia and neurasthenia had disappeared, and the man is now both feeling and looking well. Even the X-ray operator is unable to detect any point of criticism in the contour or course of the aortic arch.

Other patients attending on this date were—(1) a case of rheumatic anæmia, (2) two instances of chronic arthritis in adults, improved under a generous and stimulating dietary, (3) a case of mitral disease, and (4) unilateral retraction of the chest after pleurisy. These patients had been sent for consultation and were examined by Dr. Ewart, who made suggestions for their treatment.

MEDICAL CASES.

BY C. THEODORE WILLIAMS, M.D., F.R.C.P.

Tuesday, February 11, 1902.

A Case of Extensive Pleural Effusion.

THIS patient, a man of 33 years, had come under the observation of Dr. Dixon on the previous day. The case afforded a good illustration of the extent to which the pleural cavity may be distended with fluid. Not only was there absolute dulness,

with suppression of the respiratory murmur and absence of vocal fremitus and resonance, over the whole of the right chest, but there were unmistakable signs that the fluid had stretched the pleura so as to extend considerably to the left of the middle line. Thus the cardiac impulse was seen and felt three inches or more to the left of the nipple; the dulness of the right front was continued across the sternum almost as far as the left nipple line; and over the upper part of the left lung loud bronchophony could be heard, as though the lung tissue were condensed by the pressure of the right pleural fluid. With all this it was interesting to observe that the patient had only recently been driven to seek medical aid. He admitted that he had not been in good health during the last two months, and that he had had some pain in his right chest. It was quite obvious, too, that he readily became breathless on even slight exertion. Still the symptomatic disturbance was inconsiderable, compared with the existing physical condition. That is not a very unusual event in cases of considerable pleural effusion, at least when the accumulation of fluid takes place gradually. Every now and then a patient who makes no serious complaint, and who has perhaps been continuously engaged in somewhat laborious work, is found in the out-patient department having one or other pleural cavity practically full of fluid. The presumption is that the process has been a gradual one, and that a compensatory activity of the other lung has maintained the respiratory equilibrium. On the other hand, sudden distension of a pleural cavity, as, for example, in a complete pneumothorax, gives rise to most urgent dyspnoea, and between these two extremes there are all possible proportions between the degree of pulmonary disablement and the severity or otherwise of the respiratory disturbance. Another feature of the case worth noting is the cardiac displacement. In left pleural effusions it is common enough to get the heart pushed over into the right chest (*dexiocardia*), but effusions on the right side rarely produce more than a moderate degree of cardiac displacement, and it is quite exceptional to find, as in the present patient, the heart driven close to the left axillary line. Regarding the cause nothing can be said with confidence until the fluid has been drawn off. The patient has had no chills or rigors, and his temperature is normal. These facts oppose the suspicion of empyema, though they do not

absolutely exclude it. It may be that the case is one merely of chronic pleural effusion, though there are other possibilities, such, for example, as mediastinal tumour. Only when the nature of the fluid has been ascertained, and the condition of the chest after its withdrawal has been determined, will it be possible to give a full diagnosis and to suggest suitable treatment.

A Case of Phthisis Pulmonalis.

In this case also, as in the one just reported, there was displacement of the mediastinum; but the displacement was due to an entirely different cause. The left lung was the seat of chronic pulmonary disease, which had to a large extent become arrested by a widespread fibrosis. This was evidenced by some falling-in of the chest wall and by marked deficiency of movement. Below the left clavicle were the physical signs of a pulmonary cavity, which was known, from previous observation, to be undergoing contraction. The fibrotic shrinking in the upper part of the left lung had resulted in some drawing over of the right lung to the left of the middle line, and hence the percussion below the inner half of the left clavicle had the normal note of pulmonary resonance.

Cases of Heart Disease.

One of these patients, a man of 30 years, had passed through repeated attacks of rheumatic fever and was the subject of mitral regurgitation. There was reason to believe that the latter had been present for some years, yet the patient had suffered but little disturbance; he had a regular pulse of good quality; and neither in the lungs nor elsewhere was there any evidence of failure of the circulation. Dr. Williams referred to the frequent occasions on which evidences of mitral regurgitation are discovered in patients who enjoy good general health, and said that such cases, having perfect compensation, would usually be accepted by insurance offices with a loaded premium of seven to ten years. On the other hand, the offices will not accept, on any conditions, the subjects either of mitral obstruction or aortic regurgitation.

Dr. Williams contrasted with the case of mitral disease an example of aortic obstruction and regurgitation occurring in a

middle-aged man, in whom also there were conspicuous evidences of arterial degeneration. The significance of these facts in reference to prognosis, was discussed, and it was pointed out that they necessitated a much more serious outlook than that suggested in the case of mitral regurgitation.

SURGICAL CASES.

BY P. J. FREYER, M.Ch.

Wednesday, January 15, 1902.

Large Myoma of the Bladder in a Female; Supra-pubic Removal.

THE first case shown was a married female, aged 24, from whom Mr. Freyer had removed a large myoma of the bladder. Hæmaturia, increased frequency of micturition, and stoppage of the flow of urine had existed for three or four years, together with a tumour gradually increasing in size and projecting into the anterior vagina. When the patient first came under observation, early in October, 1901, this tumour was as large as a cricket ball. It projected in the vulva and was covered by the anterior wall of the vagina, but was free from the uterus. With a finger in the vagina and a hand placed above the pubes, the tumour could be rolled about a fixed point in the left half of the pelvis. The patient had to push it up into the vagina before micturition, which sometimes required the catheter. Cystoscopy revealed a large, smooth, globular, sessile tumour of the bladder, with large veins coursing over it, springing from the trigone and left side of the base of the bladder and in front of the left ureteral opening, which was pushed back by its base. On October 29 the patient nearly died from hæmorrhage, due to a vein being ruptured by the catheter. Next day Mr. Freyer opened the bladder supra-pubically, snipped the mucous membrane over the tumour (which was found as revealed by the cystoscope), and rapidly and easily enucleated the tumour. This weighed 9 ounces, and was found on microscopic examination to be a pure myoma. As far as can be ascertained this is the largest intra-vesical myoma on record.

The patient made a rapid recovery, leaving the hospital within a month, and is now in excellent health, untroubled by any urinary symptoms.

Five Recent Cases of Total Extirpation of the Prostate for Enlargement of that Organ.

A patient, aged 65 years, was exhibited, from whom Mr. Freyer had removed the prostate entire in its capsule five weeks ago. He had suffered from the usual symptoms of enlarged prostate for ten years, with much pain during the last two or three years. He is now in excellent health and untroubled by any urinary symptoms. The prostate, weighing 3 ounces, was shown.

Mr. Freyer then explained his method of removing the prostate entire in its capsule, as first described in the POLYCLINIC, on June 20, 1901, and the anatomical considerations under which this can be done, leaving the sheath, urethra, and sometimes the ejaculatory ducts, uninjured. Of four patients operated on by this method, two were present at the previous lecture and are now in excellent health.

Four other recent cases were described, and the prostates as removed exhibited.

(1) A patient, aged 75 years, with fourteen years' complete catheter life, operated on September 6, 1901, the enormous prostate weighing $10\frac{1}{4}$ ounces. He is now in good health, can pass his urine naturally, and retain it from six to nine hours.

(2) A patient, aged 76 years, with prostatic symptoms for thirteen years, complete catheterism for three years, extremely weak and broken in health. Large urate stone detected and removed by litholapaxy, September 7, 1901, the debris weighing 508 grains. Prostate removed entire in its capsule, October 10, 1901; it weighed $3\frac{1}{4}$ ounces. Patient now in excellent health; can pass and retain his urine as well as at any period of his life.

(3) Patient, aged 70 years, with prostatic symptoms for fifteen years; complete catheterism for five years. Prostate, complete in capsule, weighing 6 ounces, removed October 22, 1901. Began to pass urine naturally on third day; wound almost healed and quite convalescent in a fortnight. Unfortunately acute and violent mania

set in on November 6 (necessitating the patient being put under restraint), and from this he died November 13. Mr. Freyer pointed out that mania is not an infrequent accompaniment of prostatic disease, whether after operation of any kind, or in connection with catheterism.

(4) Mr. Freyer also exhibited the entire prostate in its capsule, weighing 3 ounces, removed at St. Peter's Hospital immediately before the lecture, many of the class being present. The patient was 67 years of age, and there was practically no bleeding during the operation. (This patient is now (January 28) convalescent, and passing most of his urine by the urethra, the wound being almost closed.)

SURGICAL CASES.

BY W. H. A. JACOBSON, M.Ch.

Thursday, February 13, 1902.

A Case of Thyroid Cyst.

THE patient, an unmarried woman, aged 26, complained of the presence of a small lump in the front of her neck. She first noticed it some six weeks ago, and it had shown no tendency to increase in size. Examination readily detected a rounded, firm, mass, about the size of a marble, situated just to the right of the middle line and in front of the upper part of the trachea. Mr. Jacobson regarded it as probably a cyst arising from the isthmus of the thyroid body. The other diagnosis suggested was that of a thyroglossal cyst, and a statement made by the patient seemed at first to confirm this view. This was to the effect that she had once or twice expectorated some slimy fluid "from the back of the tongue"—a remark which suggested the possible existence of a communication between the cyst and the buccal cavity. Further questioning, however, minimised the significance of this statement, as the patient admitted more or less dyspepsia during a year or so. Mr. Jacobson pointed out the great difficulty of getting

rid of thyro-glossal cysts, which after operation recur again and again. In the present case he advised that the patient be carefully watched and that if the tumour showed a tendency to increase in size it should be removed. There is in such cases some danger of sudden enlargement, leading to pressure on the trachea.

Paralysis of the Deltoid in an Infant.

An infant of 13 months was brought by its mother with the story that about four months ago the child had fallen out of bed and injured its right shoulder. Examination detected no evidence of fracture or of injury to the epiphysis, and the humerus was not dislocated. There was, however, marked atrophy of the deltoid, allowing all the bony processes around the shoulder joint to be readily defined. Mr. Jacobson suggested that the child might have been overlain, and that pressure on the circumflex nerve, caused in this way, had produced paralysis and wasting of the deltoid. The restriction of the paralysis and atrophy to a single muscle was inconsistent with a diagnosis of infantile paralysis.

The Treatment of Imperfectly Descended Testicles.

A boy, aged 13, wearing a double truss, was shown in illustration of the method of treating imperfectly descended testicles by gentle and sustained traction. Mr. Jacobson discussed the treatment by operation, and also by manipulation, and expressed his dissent from these proposals. He drew particular attention to the truss shown as most useful in these cases. It consisted of two halves, joined by straps behind. Each half carried a horse-shoe pad, and the halves, being separate, could easily be cut of unequal length, according to the level of the retained testicle on either side.

It is recorded of Dr. Barclay, who was in his day a famous teacher of anatomy in Edinburgh, that, addressing his class, he used to say : " Gentlemen ! Vesalius and his fellows were the reapers in the great field of anatomy—John Hunter and his brethren were the gleaners—and we, Gentlemen—we are the stubble geese ! "

SURGICAL CASES.

BY JAMES CANTLIE, M.B., F.R.C.S.

*Wednesday, February 12, 1902.**A Case of Supra-Hepatic Abscess(?)*

IN this case there were physical signs suggesting a localised hepatitis, yet repeated explorations in the hepatic region had failed to detect pus. The patient, a seaman, had had repeated attacks of dysentery during the last two years, each being followed by more or less evidence of hepatitis. After the last attack there had been moderate but prolonged pyrexia, troublesome night sweats, and pain in the right shoulder. The physical examination revealed an extension of the upper border of the hepatic dulness upwards in the shape of a dome-like area invading the lower right chest. There was, however, no diffused tenderness over the liver, nor was there any enlargement of the organ downwards towards the abdomen—conditions to be expected with a generalised hepatitis. It was therefore concluded that there was a localised hepatitis, attended probably with pus formation. The position, shape, and direction of the area dull to percussion, suggested the probability of the existence of an abscess on the upper surface of the liver, and pushing upwards the diaphragm. This supra-hepatic abscess, it was pointed out, forms in the space on the upper surface of the liver which is bounded by the layers of the coronary ligament. It has no necessary etiological relationship with dysentery. On the basis of the diagnosis just indicated the supra-hepatic region was punctured, with, however, so far as pus is concerned, a negative result. The patient improved for a time after the operation, but his symptoms soon returned, and this order of experience was repeated on two or three occasions. Exploration of the liver had had a similarly unsatisfactory result. Discussing the latter operation, Mr. Cantlie spoke of the great value of puncture of the liver in hepatitis, consequent on the free hæmorrhage thus produced. Used for exploratory purposes in cases of suspected abscess, the one danger is that of penetrating

the inferior vena cava. To avoid this it should be remembered that the vein has been shown to be placed from 4 to 5 inches from any point taken on the chest wall between the middle line in front and the angle of the ribs behind, that is, in a chest of normal shape having a circumference of 32 inches. Perhaps an extra allowance may be taken for chests of larger girth, but no accurate proportionate measurements on this point have yet been made. Hence the safe plan to avoid the risk of puncturing the inferior vena cava is never to use an exploring instrument more than $3\frac{3}{4}$ inches in length.

DISEASES OF THE NOSE AND THROAT.

BY STCLAIR THOMSON, M.D., F.R.C.S.

Friday, January 24, 1902.

A Case of Glosso-Labio-Laryngeal Paralysis.

THE patient, a man of 47 years, complained of difficulty in speaking. It was evident that this depended, not on a laryngeal, but on some supra-laryngeal defect. Phonation was quite unimpaired, and by the laryngoscope the vocal cords could be seen to be capable of complete approximation. The vowel sounds were successfully produced, but there was distinct failure in some of the consonants—both labials and dentals. Nevertheless it was difficult to detect any appreciable paresis of the muscles of the lips; the tongue could be protruded with apparent facility; and the soft palate showed no failure in its reflex movement. Yet the speech defect was quite beyond question. And any doubt as to the paretic nature of the affection was dispelled by a more complete investigation of the larynx, which showed that, whilst adductor movement of the cords was perfect, there was decided impairment of the abductor movement on each side. The patient also admitted occasional trouble in swallowing. Dr. Ewart had examined the patient and had confirmed the diagnosis of commencing bulbar paralysis. It is of interest to observe that, whilst the individual muscular mecha-

nisms concerned in the act of articulation, when separately tested appeared to possess a normal degree of vigour, there was yet so considerable a measure of failure in the voluntary attempt to secure their co-ordination as to cause a quite conspicuous speech defect. Other features of the case worthy of attention are the relatively early paresis of the vocal cords, and the fact that this was observed in the abductor movement. The usual course of events in bulbar paralysis presents laryngeal paralysis comparatively late in the disease, and after the tongue, lips, soft palate, etc., are all conspicuously affected. Further, the occurrence of such paralysis is commonly noticed first in the adductor muscles, so that the cords are not properly approximated in phonation, and the tone of the voice is consequently impaired. Here, on the contrary, the voice was perfect, and the ability to close the glottis was undiminished. It was articulation, not phonation, that was at fault. But when the larynx was examined as the patient took a deep inspiration, it was noted that the cords were only removed a comparatively limited distance from the middle line, that is to say, there was abductor paresis. Upon this two observations may be made. First, the suggestion may be hazarded that were the larynx critically examined from the outset in all cases of bulbar paralysis, it is possible that abductor paresis might be more frequently discovered as an early event. As this, except in its more extreme developments, involves no functional disturbance of the voice or respiration, it may readily be overlooked. The patient's phonation in such circumstances is perfect; the laryngoscope shows accurate apposition of the cords in the act of phonation; and there is a fair amount of abduction during deep inspiration. Thus it may almost excusably be concluded that the laryngeal muscles are unaffected by the disease, the fact that abduction of the cords is not carried to the fullest extent failing to attract attention. It is well known that in laryngeal paralyses dependent on pressure on the recurrent laryngeal nerve, it is the abductor movements which first suffer, paralysis of adduction being invariably a much later event. Here it is comparatively easy to appreciate the abductor failure, because it is in the great majority of cases unilateral, and the free movement on the unaffected side forces the defect of the paretic cord on the attention. A more critical eye is needed to detect a slight abductor

paresis involving both sides, as there is then no immediate normal standard with which the movements of the cords can be contrasted. A second comment arising out of the case is that a condition of the larynx of a definitely abnormal nature may exist without disturbance of the voice function. Cases have been frequently presented in our clinics emphasising the importance of laryngoscopic examination in every patient the subject of persistent aphonia or hoarseness. The present case carries the lesson that such an examination may have considerable value even when, as far as the voice is concerned, the functions of the laryngeal mechanisms appear to be discharged with unqualified success.

A Case of Tracheal Syphilis.

The patient, a man of about 30 years, complained of slight huskiness, but was otherwise free from pain and discomfort. Examination revealed some congestion of the vocal cords. Otherwise the larynx appeared to be normal. Below the level of the glottis, however, a number of blackish crusts could be seen adhering to the mucous membrane of the trachea. A small ulcer was also present on the left anterior pillar of the fauces, and a second ulcer was detected on the mucous membrane of the hard palate. A probe introduced into the latter detected the presence of carious bone. This last-mentioned fact made the diagnosis of syphilis certain. Ulceration leading to perforation of the hard palate is always syphilitic. The feature of the case which was emphasised by Dr. StClair Thomson was the condition of the trachea. There could be no doubt, he said, that there was specific ulceration of the tracheal mucous membrane, and he drew attention to the existence of this without pain or discomfort. When such a condition exists as the sole manifestation of syphilis, its true nature is very apt to be overlooked. The patient may complain of nothing more than occasional attacks of coughing, accompanied by the expectoration of black scabs. These attacks tend to occur on waking in the morning, the crusts which have formed on the ulcerated surface during the night being then coughed up, and the patient for the rest of the twenty-four hours remaining free from discomfort. Such a history, or the detection by the laryngoscope of dry adherent crusts on the surface of the tracheal mucous membrane, is highly suggestive of

syphilis. There is a considerable risk attached to specific disease of the trachea. It may be attended with a more or less acute sub-glottic œdema causing serious respiratory difficulty, or, when cicatrisation is advanced, this may lead to organic stricture and the necessity for tracheotomy. These considerations make the claim for recognition of the disease all the more urgent.

A Case of Tonsillitis.

The case of a patient with tonsillitis was the opportunity for some remarks on the usual position of the abscess which may result from inflammation in the region of the fauces. In the great majority of cases, it was pointed out, the abscess forms, not in the tonsil itself, but in the peri-tonsillar tissue above the tonsil. Hence, in most quinsies incision of the tonsil fails to evacuate the pus. The usual site for puncture is a point where a horizontal line through the base of the uvula crosses a vertical line corresponding to the anterior faucial pillar. Puncture is best effected by means of a fine-bladed forceps. These are pressed against the abscess so as to enter its cavity, and then, during withdrawal, the blades are separated, thus enlarging the opening as in Hilton's method, and securing free evacuation of the pus. Occasionally an abscess forms behind the tonsil, in the lateral wall of the pharynx. If pus forms in the tonsil itself, it is almost invariably in the form of small scattered collections which come to the surface and discharge themselves spontaneously.

Perforations in the Faucial Pillars.

A man was shown who exhibited a small circular perforation in the upper part of each anterior faucial pillar. Dr. StClair Thomson remarked that considerable difference of opinion exists regarding the interpretation to be placed on such perforations. By some they are regarded as congenital defects due to an error in development. Others attribute them to the effects of scarlet fever, and point to their association with a puckering of the posterior pharyngeal wall, as if from cicatrisation after superficial ulceration. Dr. Thomson has frequently seen the perforations apart from any such puckering; and this fact, together with the absence of signs of cicatrisation from

the edges of the perforations, inclines him to the view that they mean developmental defect. He suggested that those who have the opportunities of family practice might do something to settle the dispute by looking out for these perforations in young patients, and more particularly in those who had never had any scarlatinal or other affection of the throat. A useful contrast to these quasi-congenital perforations was afforded by a syphilitic patient in whose soft palate, on one side, there were several small punched-out ulcers, one or more of which perforated the palate. It was remarked that these ulcers, when they heal, form slightly-puckered stellate cicatrices, which have a definite value for diagnostic purposes.

Tuberculosis of the Larynx.

Discussing a case of commencing tuberculosis of the larynx, Dr. StClair Thomson said that in many of these patients there is marked tenderness of the cervical muscles. On grasping the supra-clavicular region between the fingers and thumb, the patient complains of definite pain, whilst similar compression applied to other muscles causes little or no discomfort. This may assist the diagnosis in a doubtful case. After insisting on rest of the voice as an absolutely essential part of successful treatment, he said that lozenges containing $\frac{1}{12}$ to $\frac{1}{6}$ grain of heroin were valuable soothing agents. Heroin gives the sedative influence of morphine without the disadvantages which attend the use of the latter remedy.

DISEASES OF THE NOSE, THROAT AND EAR.

BY DUNDAS GRANT, M.D., F.R.C.S.

Friday, January 31, 1902.

Cases of Traumatic Rupture of the Tympanic Membrane.

(1) THIS gentleman has been adventuring in the football field, and he has been kind enough to come with me to-day so that you may see the traumatic rupture of his left tympanic membrane. He does not know exactly how it happened, but he must have had a flat slap upon the orifice of the ear, so that by the pressure of the air the membrane was ruptured. The rupture is situated in front of

the handle of the malleus, and as it is extremely difficult to see I will first explain to you what it is like.

There are the usual features of the drum of the ear, such as the handle of the malleus, and the bands running forwards and backwards. But at the anterior part of the membrane and low down there is a small oval opening, difficult indeed to recognise as an opening because you see through it the inner wall of the tympanum, which is almost exactly of the same colour as the tympanic membrane itself; and round the edges of the opening are some minute spots of hæmorrhage. It is very difficult to see for two reasons; one being the projection of the anterior wall of the meatus, and the other, as already mentioned, that the inner wall of the tympanum in these cases is perfectly white. In most perforations with which you are familiar the inner wall of the tympanum is red, because they are usually the result of suppurative inflammation, and the inner wall of the tympanum is inflamed. The most usual form of perforation is the kidney-shaped perforation, and with this the inner wall of the tympanum is perfectly red, thus contrasting very strongly with the one we have before us. Another form of perforation is the one which takes place in an acute suppuration of the middle ear, when a very small perforation looks quite black, and the rest of the membrane, especially round the perforation, is intensely red; the anatomical features of the membrane are very often quite obliterated by the inflammation. On the other hand, a traumatic perforation, as in our present patient, looks white. Again, sometimes with even a fairly large perforation from inflammatory causes, when the patient blows his nose, the air goes through with some difficulty, the reason being that, as a result of the inflammation, the Eustachian tube is narrowed; but in a traumatic perforation there is nothing of the kind, and the extreme freedom with which the air goes through is very characteristic.

With regard to treatment, what I did was to sterilise the meatus by wiping it out very thoroughly with a solution of biniodide of mercury in spirit; the chances of infection from the naso-pharynx amount to nothing. The great thing is to avoid interference by syringing or the instilling of drops; when blowing the nose the patient should stop up only one nostril at a time.

(2) Mrs. B. S., aged 31, came under my care at the Central

London Throat and Ear Hospital on January 30, 1902, on account of deafness which came on suddenly a week ago. The patient states that she knocked her ear against a post ; she noticed at the time a noise in the head when she blew her nose. There is a perforation in front of the handle of the malleus, but it is surrounded by an area of redness ; it was slightly inflamed when I saw it for the first time, there was also a small ecchymosis at the lower part on the posterior wall ; the air passes through the perforation with extreme ease. In this case there is evidence of an old suppuration which has now subsided altogether ; below the tip of the handle of the malleus the membrane is almost entirely gone ; the upper part of the membrane is present ; there is so much hæmorrhage and some inflammation round the edge of the perforation that it has quite lost its character of a traumatic rupture. Below can be seen a depression and a sort of band. In her case there has no doubt been former suppuration causing cicatricial contraction and the formation of bands, so that the perforation has taken place through the old cicatrix and not through the healthy membrane.

Case of Post-Diphtheritic Paralysis.

Miss W., student at the R.A.M., came to consult me a few days ago on account of the peculiarity of her voice. She noticed this a week before Christmas. The sound appeared "to come through the nose," and when she drank there was regurgitation through the nose ; she has no difficulty with her eyesight, and no shakiness on the legs ; she has difficulty in the sound "b." She has improved considerably since I to-day applied the galvanic current, which produced very free contraction of the muscles of the soft palate. It can be seen how inactive the palate is. I need hardly say that in such cases there is often loss of accommodation for near objects, and also loss of knee-jerks. In this case the knee-jerks are not absent, and there is every probability that the patient will very quickly get well.

I should have liked to have brought another case, an in-patient at the West End Hospital for Nervous Diseases, a little girl whose chief difficulty is in vision ; she cannot see near objects ; there is some peculiarity in her speech, absolute loss of knee-jerks, and her pulse is very rapid.

The present patient is taking internally strychnine and arsenic and is instructed to take nourishment freely, and not to sing just yet ; one application of the continuous current has made a difference already. The paralysis came on about a fortnight after she seemed to have got well of the diphtheria ; I do not think she was treated with antitoxin. Her medical adviser was convinced that the case was one of diphtheria, though no bacilli were reported to be present, and he insisted upon the other members of the family taking all precautions, with the result that no one else was infected ; the sequelæ have shown that his clinical diagnosis was correct.

Case of Tuberculous Laryngitis.

Philip C., aged 23, came under my observation on January 23, 1902, on account of extreme pain in swallowing. There is not much the matter with the epiglottis, but there is a slight swelling of the right arytenoid fold, and enormous swelling of the left one ; there is a deep excavating ulcer occupying the inner surface of the ary-epiglottic fold, the posterior part of the ventricular band and of the vocal cord ; it is one of the " worm-eaten " looking ulcers ; at the posterior part it is extremely deep, and both during phonation and inspiration the left half of the larynx is fixed. The worm-eaten appearance of the ulcer is a characteristic of tuberculous laryngitis ; there are also confirmatory signs in the thoracic organs, and the case is certainly one of tuberculous laryngitis. One of the steps in the progress is often the occurrence of perichondritis round the arytenoid cartilage, so that sometimes when making the *post-mortem* examination you find that the upper part of the arytenoid cartilage is one little calcareous nodule ; sometimes this gets extruded ; very frequently you find at the neighbourhood of the vocal process, or just above it, there is a sort of sinus leading into the cavity in which this little calcareous nodule lies.

It is very likely that such is the case with the patient before us, and it is not improbable that he may cough out the necrosed portion. The chief symptom of which he complains is the pain in swallowing.

On the last occasion when I had the honour of discussing some cases here, I showed you a method, which was quite new to

me, of introducing powders into the larynx by means of a bent tube. The patient will show you how he gets the powder into his larynx; he puts the bent tube into the back of the throat, against the soft palate, and puts the outer extremity of the tube into the powder, and draws the powder into the larynx by means of inspiration; it will be seen that some of the powder gets on to the ulcer and some inside the posterior part of the larynx. The powder I have used contains one part of resorcin to two parts of orthoform, and if the patient uses it in the morning he finds that he is able to take his breakfast and his dinner, though at teatime he has a difficulty in swallowing again; I see no reason why he should not use the powder in the afternoon again. He notices a difference in the pain in swallowing, and to the best of my belief there is a little improvement in the ulcer.

I have made use of this method in several cases lately; one was a case of tuberculosis of the larynx, with a very acutely supervening oedema, and the man has been able to take food ever since. The method is simple enough, and any patients to whom I have recommended it have had no difficulty in carrying it out; the great advantage of it is that they are able to get the powder into the larynx; in a great many instances in which an insufflator is used for blowing powder into the larynx, it does not get there, especially when used by one who is not an expert; but with this method the patient is able to do it for himself, and, so far as I have seen, the method is an extremely valuable one.

Case of Fibrinous Rhinitis.

Albert D., aged 7, came to the Central London Throat and Ear Hospital on January 23, 1902, on account of stuffiness in his nose. I found the left nostril completely filled with a somewhat gelatinous sort of exudation; also he had upon the forehead spots from some vesicles which had been there, also in the middle of the lip. He had had the stuffiness in the nose about a fortnight before he came to the hospital. Only one nostril was affected; the discharge was very gelatinous and very difficult to get away, and when it was detached the surface bled. It is a typical case of fibrinous rhinitis. A great many of these cases have been attributed to the Klebs-

Lœffler bacillus, so that we had a culture made of this one, but found in it that there was no such bacillus ; it contained the bacillus mesentericus which, I suppose, is somewhat related to the bacillus coli communis, and in addition some diplococci, but otherwise nothing specific. The little boy has had no sore throat. The treatment I have given him has been syringing with lime-water, one of the best things we have for dissolving these fibrinous membranes ; it is not painful, and it is doing very well with him. With regard to the herpetic eruption on the forehead, it is difficult to say whether the two together have some nerve origin. The blisters lasted one day.

Case of Senile and Anæmic Nerve Deafness.

Mrs. A., aged 66, came to the Central London Throat and Ear Hospital on January 30, 1902, on account of dulness of hearing of two years' duration, which had come on gradually. Her hearing for the watch is very defective indeed, about $\frac{1}{2}$ " , but she hears the whispered voice at an extraordinary distance, so that the hearing for speech is better than for the watch. She has diminished bone-conduction, and she hears the tuning-fork longer through the air than through the bone ; that is as it would be with a normal tympanum, so that practically her tympanum is normal, and the deafness has to be sought for somewhere else. It is, therefore, nerve deafness. In nerve deafness, especially when due to disease of the extension of the auditory nerve in the labyrinth rather than in the centres, the loss of hearing for the highest pitched tones is marked. She hears Galton's whistle at 3.6 mm., that is to say, she hears nothing higher than the note produced by a closed pipe of 3.6 mm. in length. Her age is 66 ; she hears worse when standing up than when lying down, and worse when tired, and when she is cold she can hardly hear at all. She has been a widow in very reduced circumstances for three years, and it is chiefly during this time that her hearing has got dull. Her age has something to do with the deafness, but the *res angustæ domi* have helped very much, and the best thing for her is to have her strength kept up in every way. She has "wind on the stomach" from the atonic dyspepsia to which people of her age, sex and rank in life are so liable. She is taking nux vomica.

Case of Chronic Suppuration of the Middle Ear with Polypoid Granulations.

Beatrice S., aged 16, came to the Central London Throat and Ear Hospital on January 30, 1902, complaining of bleeding from the ear of six months' duration. When there is discharge and bleeding from the ear, it is pretty certain that there is a vascular granulation. In her case you can almost see this without a speculum; it seems adherent to the upper part, and it almost amounts to a polypus, which is mulberry-looking, and probably growing from the attic, because when Politzer's method of inflation was used in her case no air came through, and if a polypus as deep as this one came from the middle ear it would be associated with perforation, and air would get through. I will report upon this case next time, and I have little doubt we shall find my view corroborated after removal.

Case of Polypus of the Left Ear.

Fanny I., aged 18, came to the Central London Throat and Ear Hospital on January 23, 1902, on account of a growth in her left ear, which had come on gradually during three years. There was a polypoid mass of granulations almost blocking up the meatus and growing from the posterior wall of the meatus. There is ample evidence of old suppuration of the middle ear. After I had removed the polypoid granulations I found there was an area of bare bone on the posterior wall of the meatus, and there is possibly a communication with the mastoid cells. The question in diagnosis is whether it was due to a furuncle on the posterior wall of the meatus, or to disease of the mastoid cells. I believe it is the latter. In her case I used antiseptics in the first instance, and I shall probably again have to scrape the area of the posterior wall and blow in iodoform, but it is quite likely that the radical mastoid operation will have to be performed, as I expect there is disease on the other side of the partition.

Case of Ossiculectomy.

Amelia E., aged 23, had had discharge from the ear for eighteen years. When she first came to the Hospital the astringent alcohol

treatment was used, but that did not bring the discharge to an end; there was an opening in the attic from which pus was coming, and when that is the case it is often kept up by caries of the ossicles; it is sometimes also kept up because the ossicles form a sort of barricade preventing free exit of pus. I have performed ossiculectomy for her, and if you look very close at the ossicles you will see that on the neck of the malleus there is some erosion, and also upon the head of the incus there is very evident caries. Since this operation, which was performed a fortnight ago, the discharge has stopped, the hearing is better, but the noises in the head still continue. She is an irritable subject, and seems to give her mother "rather a bad time of it" through her impatience with her tinnitus. I shall try the effect of bromide of potassium internally.

Case of Mastoid Operation.

Archibald S., aged 21, had had discharge from the ear for fifteen years; it had not answered to any treatment carried out through the meatus; he sometimes had giddiness and headache, and it was found necessary to do the radical mastoid operation. In many respects it was very successful; externally there is no disfigurement whatever, but internally there is a little narrowing about half way in, which mars the artistic perfection of the operation, although it does not seem to have interfered with the result desired.

TWO EXAMPLES OF INTRAUTERINE AMPUTATIONS.

THE two photographs¹ here reproduced (pp. 155, 157) represent conditions which, though far from common, have long been recognised as occasional occurrences. They are examples of intrauterine amputations, and in each of them it is the right upper limb which has suffered. The severity of the injury is very different in the two cases. In the first case the patient has lost the four inner digits. Fortunately for himself he retains a perfectly well-formed and undamaged thumb, and by opposing this to the palm or to the stumps

¹ The photographs were kindly taken by Dr. J. H. Teacher, of the Hunterian Museum, University of Glasgow.

of the fingers he is able to make much practical use of his hand. Thus he uses his right hand for writing, and produces a fair specimen of the art, more especially in view of the fact that his occupation does not make much claim for expert penmanship. The second photograph (p. 157) was obtained with difficulty, as the patient was very sensitive in regard to his deformity and only reluctantly consented to his curious limb being figured. At first sight it is not perhaps very

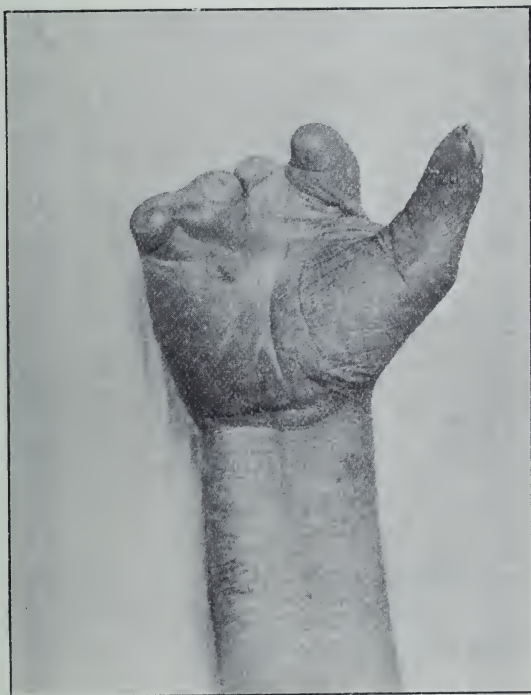
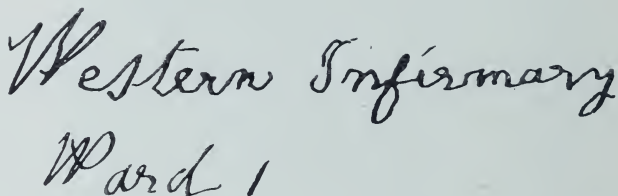


FIG. 1.—*Photograph of right hand, showing amputation (intrauterine) of the four inner digits.*

easy of interpretation. What it represents is the right elbow joint and the adjacent parts of the upper arm and forearm. The upper arm was perfectly well formed in every respect. The forearm, as is seen, is represented only by a conical-shaped stump, and on the outer aspect of the extremity of this are three well-defined, short, rounded processes, separated one from the other by intervening depressions. These are doubtless rudimentary digits. It is this

feature which makes the photograph particularly interesting. Taking it for granted that the patient had in the early stages of his intrauterine existence a well-formed right upper limb, and that he lost his right hand and greater part of his right forearm as the result of some intrauterine accident, there is here seen an attempt to reproduce the severed portion. And it is to be noted that the effort is made in regard to the most distal and most complex portion of the limb. In this respect the attempted new development may be said to follow the original line of limb formation, for the earliest appearance of each limb in the embryo is in the shape of a small, flattened, projecting process or bud, which represents the distal segment of the limb, and on which, at an early date, develop four notches marking off the intervals between the digits. The elongation and differentiation of the proximal segments of the limb



Western Infirmary
Ward 1

FIG. 2.—*Hand-writing of patient who has lost his four inner digits by intra-uterine amputation.*

is a later process, and it is by this growth on its proximal aspect that the distal segment is, as it were, pushed out from its primary attachment to the embryonic trunk. In the case illustrated in the second photograph (p. 157) there is a repetition, in an abortive form, of the original plan and method on which the limb was developed. The patient doubtless had originally a perfect right upper limb. From some cause or other during intrauterine life this was amputated in the upper third of the forearm. In these circumstances Nature has made an effort to reproduce the severed member, and in doing so she has followed her original plan of pushing out, as a primary movement, the elements of the distal segment, as is indicated by the short processes and intervening grooves which correspond respectively to the digits and to the intervals between them. It is somewhat curious to find a demonstration of such a capacity for

reproduction of parts of complex organisation in the tissues of the highest member of the animal series. In the more lowly forms of life it is well known that an entire member may be replaced by a process of this order. But as organisation becomes more complex, and tissues become more highly specialised and differentiated, the faculty of reproducing lost parts rapidly diminishes, until, in the higher types of organisation, it is, for all practical purposes, lost.

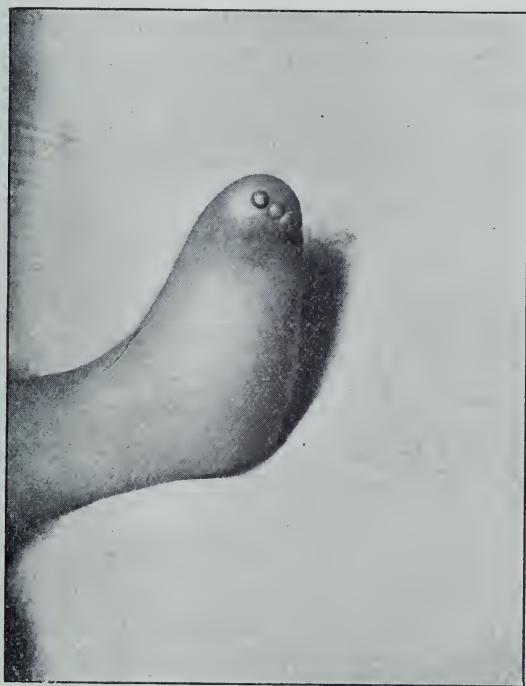


FIG. 3.—*Photograph of right upper limb, showing amputation (intrauterine) of the forearm and the formation of rudimentary digits on the extremity of the stump.*

The evidence of such cases as the present, however, shows that even in man, at least in early embryonic life, the faculty of local reproduction exists in some degree, and it is as a demonstration of this truth that the photograph can claim a special note of interest.

Regarding the manner in which these deformities are produced, there is abundant evidence that they arise by actual amputation of parts. In the first place, there is the fact of cicatrisation to be

observed on the extremities of the truncated parts. This can be readily observed in the first photograph, and though less distinct, it was quite appreciable in the second case. In the second place, at least one fœtus has been described in which some of the fingers and toes were found partially divided by bands of coagulable lymph or false membrane, and a similar state of matters has been observed in reference to the forearm. What seems to happen is that in consequence of a defective formation of amniotic fluid, or from some other cause, the amnion in early embryonic life is not carried away from the newly-formed skin of the fœtus, and that adhesions form between the two structures. Subsequently, the cavity of the amnion becoming distended, these adhesions are rendered tense; and if one or more of them should pass round a limb, this becomes strangled and may be gradually divided, the proximal part having perhaps first become atrophied in consequence of obstruction to the circulation. In some cases the strangling agent would appear to be the umbilical cord. Further, there is reason to believe that to produce amputation it is not actually necessary that a band should surround the limb. The mere weight of the limb resting on a tense adhesion or umbilical cord, would appear to be sufficient to cause division of the tissues.

It is hardly necessary to add that such cases as the present are in quite a different category from that occupied by instances of limb defect, the result of aborted or arrested development. In the latter there is a deficiency of developmental impulse, and not a mutilation by an external agent. Such deficiency may be limited to suppression of one or more digits, or it may extend to an entire absence of all the four limbs.

C. O. H.

AN AUTHOR WHO HAS NEVER WRITTEN A BOOK.—“One of the most popular misquotations (of which so formidable a list might be compiled with ease) is the allusion to Job xxxi., 35: ‘Oh . . . that mine *adversary* had written a book.’ If asked to name an eminent author who has yet never written a book, the average reader would certainly think he was being made the victim of a piece of buffoonery. But, as Sir Michael Foster told the Authors’ Club last Monday, Mr. A. W. Rücker, F.R.S., the new Principal of London University, in spite of his emience as an author, has never written a book, although he has contributed some of the most valuable papers among the Transactions of the Royal Society.—*Westminster Gazette*.

A BRIEF STATEMENT OF 410 CASES OF LEPROSY TREATED IN THE NORTH WEST PROVINCES, AND OUDH, INDIA.

We are indebted for this communication to the courtesy of Mr. E. T. Simpson, Civil Surgeon and Chief Health Officer, Rai Bareilly, Oudh.

Type.	Number.	Duration of Disease.					Sexual State.			Parts affected.					Results.					History of Contagion, etc.			
		Under one Year.	One to two Years.	Two to five Years.	Five to ten Years.	Over ten Years.	Impotent.	Children.	Doubtful.	Upper and lower Extremities.	Upper alone.	Lower alone.	Face and Extremities.	Body.	Face, Body and Extremities.	Cure.	Class I.	Class II.	Nil.	Died.	Family affected.	Mixing with Lepers.	No History.
Anæsthetic	..	17	23	76	54	38	34	133	38	72	12	7	5	14	98	16	46	39	107	9	48	20	140
Mixed	..	5	6	67	49	58	44	118	23	3	14	3	42	0	123	2	39	20	124	30	42	27	116
Tubercular	..	1	0	7	5	4	10	5	2	4	1	0	6	2	4	—	3	—	14	2	4	5	8

REMARKS.

These cases were treated from 1893 to 1900. The average age of the patients was 30 years. They came from all parts of the North Western Provinces and Oudh in India, and three from Burnah. 41 per cent. were meat eaters, 3 per cent. Burmese, and who were in the habit of eating salt fish and putrid fish, 2 per

cent. fishermen and boatmen who ate fish and the flesh of the Crocodile, and 54 per cent. vegetarians pure and simple.

Type.—Three types of the disease are given. The anæsthetic and tubercular forms, although distinct at first, invariably, however, terminate in the mixed type.

Average age.—The cases treated were chiefly adults, the ages ranging between 18 and 60 years. Four were under 16 years of age.

Duration of Disease.—As noted in the table; some of the cases treated had the disease for over twenty years.

State of Generative Organs.—Many writers state that all lepers are bound to become impotent. The table shows a large number who had not lost procreative power.

Parts affected.—The face and extremities were primarily affected in the larger number of cases.

Results of Treatment.—Cures, 18; class I., 88; class II., 59; no benefit, 245. I have noted eighteen cases of cure. They may reasonably be put down as cures, for the symptoms had entirely disappeared, and in two cases the patients were under observation for four years after the symptoms had disappeared, without any evidence of recurrence.

Class I. represents slight improvement in the leprosy symptoms.

Class II., marked improvement, short of cure.

Arsenic internally, gurjun oil externally and internally, carbolic acid externally and internally, appeared to do the most good. Among other remedies employed were perchloride of mercury, ichthyol, resorcin, thyroid extract, zinc sulphate, etc., etc. In some cases nerve stretching was practised.

Most of the cases under treatment improved in general health.

The strict hygienic conditions under which they were placed had, I should think, a great deal to do with the improvement.

Deaths.—These numbered 41; 60 per cent. of these died from intercurrent affections.

Post-mortem examination in all showed leprosy deposits in one or more organs.

History of Contagion.—In ninety-four instances one or more members of the family were afflicted. Fifty-two cases gave a history of intercourse with lepers (social and otherwise).

CORRESPONDENCE AND ANSWERS.

SOCIAL ETIQUETTE AND CHILD-BEARING.—The following passage occurs in Brydone's "Tour through Sicily and Malta," written towards the end of the eighteenth century:—"There are here a number of particular conversations every

night, and what will a good deal surprise you, they are always held in the apartments of the lying-in ladies, for, in this happy climate, child-bearing is divested of all its terrors, and is only considered as a party of pleasure. This circumstance we were ignorant of until t'other morning. The Duke of Verdura, who does us the honour of the place, with great attention and politeness, came to tell us that we had a visit to make that was indispensable. 'The Princess Paterno,' said he, 'was brought to bed last night, and it is absolutely incumbent on you to pay your respects to her this evening.' At first I thought he was in joke, but he assured me he was serious, and that it would be looked upon as a great unpoliteness to neglect it. Accordingly, we went about sunset, and found the Princess sitting up in her bed, in an elegant undress, with a number of her friends around her. She talked as usual and seemed perfectly well. This conversation is repeated every night during her convalescence, which generally lasts for about eleven or twelve days. This custom is universal; and as the ladies here are very prolific, there are, for the most part, three or four of these assemblies going on in the city at the same time."

* * *

PROFESSOR CLELAND ON THE FORM OF THE HUMAN SKULL.—"The source of the difference between dolichocephali and brachycephali seems lost in antiquity, even though the two forms mix and graduate one into the other. But one thing seems certain, that no amount of civilisation and development of brain will convert a brachycephalic into a dolichocephalic race. On the other hand, if such a skull as that of the Kaffir be subjected to the influences of civilisation, it may be expected to lose its roof-shape and expand laterally, and as the brain becomes at the same time richer in convolutions, it may be difficult to estimate the future of such a race if it preserves a fine development of the whole body."—*Memoirs and Memoranda of Anatomy*.

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PHILOSOPHY AND DIET.—In Mr. Graham's recently published work on "Scottish Men of Letters" (A. and C. Black), the following story is told of Dr. James Hutton and Dr. Joseph Black, two Edinburgh worthies of the time of Adam Smith: "They had argued themselves above all popular prejudices on diet, and resolved to carry their opinions into practice. Since the ancient world partook of testaceous creatures of the sea as delicacies, why turn up the modern nose in abhorrence of those that crawl on dry land? Why not eat snails? They were wholesome; they were nutritious; and did not epicures of old prize the molluscs fed in the marble quarries of Lucca? The two emancipated philosophers determined, therefore, to have snails for supper. They sat down to the feast. Silently they looked at the dish; shyly they refrained from looking at each other; slowly each took a mouthful—their gorge rising in flat rebellion as they did so. At length Dr. Black, in slow, delicate, tentative voice, remarked in his gentlest manner, 'Doctor, don't you think they taste a little—a *very* little queer?' 'Queer!—dawmed queer! Tak' them awa'! Tak' them awa'!' vociferated Dr. Hutton, rising in loathing." The "emancipated philosophers" made no further attempts to demonstrate the absurdity of "popular prejudices on diet."

* * *

THE LARCH DISEASE.—At a recent meeting of the Royal Scottish Arboricultural Society, the Council was authorised to take such steps as may seem necessary to enquire into and experiment as to the cause and effect of the disease of the larch.

* * *

THE USE OF COFFEE.—The amount of coffee cleared from bond during the year 1901 was 16,613 tons, which is 2,400 tons in excess of the total for 1900. Until

the last few years the import of coffee has been steadily falling during a quarter of a century. It is said that the person who opened the first coffee-house in Fleet Street was indicted for annoying his neighbours "by the production of evil smells."

* * *

AGAINST TOO MUCH READING.—It was Hobbes of Malmesbury who said, "If I had read as much as some others I should have been as ignorant as they are." Someone else said of one of his friends that he had burdened his faculties with so much book knowledge that they could not move. Sydenham's advice to his friend "to read Don Quixote" is well known, and is not wholly without its application to the present day.

* * *

WE borrow the following from a recent issue of the *Westminster Gazette* :—

THE SLUM DOCTOR.

Into the mud of existence, into the gutters of life,
Somehow or other—who bothers, my brother ?—I've drifted, dragging a wife ;
Somehow or other, what matter how ?—bread's to be earned this way—
Punk and impostor with cut-throat and coster pull at my bell all day ;
Fine to be framed in the splendour and gilding of Cavendish-square,
Booming reliance on medical science with glittering carriage and pair,
Rolling thro' glory and guineas up to a riband and star,
Famous physician, a perfect patrician—specialist ! god in the car !

O ! he wins in an hour what I wring in a year,
For my man is a docker and his is a peer ;
He fishes in waters all liliated and sweet,
I grub in the puddles that slop at my feet ;
And the East is the East, and the West is the West,
But phossy jaw aches like a cold in the chest,
So we fight the same mystery, Sin and Disease,
And the difference is only a matter of fees !

Look you, for me is the struggle, down in the filth and the fog
Pinned here a fixture with pill-box and mixture, to doctor a Rough or his dog,
Pinned here a fixture, glad too of that !—how should we live, dear girl ?
Thank God, the weaver and sempstress get fever, suffer like Bishop and Earl !
Down on my knees at the pallet of squalour and horror and sin,
Over foul bodies knowing God's rod is, keeping the gasping life in,
Earning my slippery coppers, gnawing the meat from the bone,
Living in clover ! but, ah, when it's over, dear heart, can you battle alone ?

For there's nothing to save in the alleys and slums,
Tho' we lick at the platter and grope for the crumbs,
O ! it's always a famine, and always a drouth,
And it's living each day from the hand to the mouth,
And it's living all blunted with Hunger and Cold
And Labour left starving because it is old—
O ! my wife's in the kitchen, I answer the door,
And we're living, somehow, on the pains of the poor !

HAROLD BEGGIE.

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. VI., No. 4.—APRIL, 1902.

TUBERCULOSIS IN SOUTH AFRICA.

THE vocation which the Polyclinic has marked out for itself includes the collection of evidence as to disease in all parts of the world. We have repeatedly claimed the attention of the profession for our great South African Territories, as being those which, at the present time, have the most pressing claim upon us. It is there that, within a very short period, a development of the British nation is likely to take place, which will excel in importance and extent anything which the most vivid imagination is easily able to conceive. Everything, therefore, which concerns the health of South Africa and the physical well-being of the various races which make up its population, is of the utmost importance to the Empire. Hitherto it has been the custom in England to believe that the climate of South Africa is one of almost unique advantages for tuberculous affections of the lungs. We have sent our consumptives there with sanguine expectations. These have in some cases been fully justified by the event, but in many others disappointment and misery have ensued. Still, however, it has been assumed, until very lately, that the failures were due simply to the cases being sent too late, and no suspicion was entertained that, after all, the climate is not one possessing advantages which are not in most instances more than counterbalanced by drawbacks. During recent years, however, grave fears upon this head have been dawning upon

the minds of those on the spot, and at the present time many of them are very emphatic in deprecating the exportation of British invalids in any stage of the disease, excepting the very earliest. It is stated that tubercular phthisis is of not infrequent occurrence throughout South Africa, both in those of European descent and the native tribes. As regards the latter, amongst whom it is especially common, it is also feared that it has recently very much increased.

It need not be said that most interesting problems are concerned in the suggestions just made. Why should tuberculosis prevail amongst the coloured races more largely than amongst the whites, and, above all, why should it be increasing among them? What are the conditions which, in South African life, counterbalance the advantages of a dry air, a sunny sky, and a high elevation above sea-level. Our first enquiry must be as to the truth of the allegation. Are these advantages counterbalanced? and to this task we propose to devote the present article. We have now before us the reports on the Public Health, published by the Cape Government, for seven consecutive years. These reports contain much very valuable matter supplied by local medical officers, but they are not by any means systematic as to details, or uniform in method. The data do not yet exist for the construction of trustworthy statistics, and we must, therefore, perforce be content to adduce the evidence in a somewhat fragmentary form. It may perhaps not be the less convincing on that account.

To begin with Cape Town itself and its suburbs—Durbanville, Woodstock, and Maitland. This city is shut in by its surrounding mountains, and has in part a north exposure, equivalent, of course, in our latitude to a southern one. It is said by the reporter whom we are about to quote, that its climate is for "at any rate eight months of the year extremely unfavourable to the tubercle bacillus." Life in the open air is practicable and pleasant in almost all seasons. Yet a special report published in 1897 gives the following facts:—During the four preceding years 282 Europeans and 648 coloured persons had been registered as having died of phthisis in Cape Town. The total numbers of deaths registered from all causes during the same period were Europeans, 2,598; coloured, 4,522. Thus we see that about one-ninth of all the recorded European deaths was

due to phthisis, and one-seventh of the coloured population. It is pointed out that whilst part of the European death rate might be due to imported cases from England and elsewhere, this would not apply to the coloured population. During the period referred to typhoid fever was responsible for only 200 deaths against the 930 due to phthisis. Concerning the Wynberg, Rondebosch and Mowbray districts, we have from Dr. Syfret the statement that he considers tuberculosis "to be on the increase among the poorer white and coloured populations." These districts contain some of the best residences near Cape Town, including De Groote Schuur, the favourite home of Mr. Cecil Rhodes. They have, however, their poorer quarters, and Dr. Syfret adds in explanation of the increase of phthisis, "this is not surprising when one takes into consideration their insanitary and crowded dwellings."

From Cape Town and its neighbourhood we may pass 50 miles north to the pleasant and prosperous old Dutch town of Malmesbury. This town is well built, with wide, tree-shaded streets, and apparently every condition likely to conduce to health. For 1899 Dr. Roux, the medical officer of health, was able to report that in the town itself no white person had died of phthisis, but there had been twenty-one deaths of the coloured. In the rest of the rural district under his charge there had been five deaths of Europeans and twenty-six of coloured. Now the ratio of coloured to European in the Malmesbury district is as ten to thirteen, and these figures prove that phthisis is very disproportionately common amongst the coloured population. Malmesbury is a corn-growing district.

Passing further north into the rural country just eastward of Saldanha Bay we have from Dr. Riccard, the medical officer for the village and district of Hopefield, the following important statements:

"Consumption was responsible in 1899 for a high death rate among coloured children. In five cases the disease appeared in the form of an acute miliary tuberculosis. This prevalence of consumption amongst coloured children I attribute to poor feeding, scanty clothing, and overcrowded living, and then exposure of this undermined constitution to the tubercle bacillus which must be found in the mission schoolroom where consumptives daily attend. The only way in which this could be remedied, I think, is to close these schools during the ploughing and harvesting seasons, and so give the coloured child a chance to assist his father in earning something towards the support of the younger members of his family, and also place himself in the position of filling his belly three times daily."

There is probably no reason for believing that the facts as regards Malmesbury differ materially from those which might be recorded of many other farming districts in Cape Colony. We will avoid repetition and pass across the country to the south-east and give those for King William's Town. Dr. Chute, the medical officer for that place, has taken much trouble in the compilation of his annual reports, and his statements are valuable. From his tables of causes of death during 1896 we find that out of eighty-six Europeans there were five from phthisis and one, an infant, from "tabes mesenterica," whilst out of ninety-six deaths of coloured persons twelve were from phthisis and three others from tuberculosis. It may not be without its interest to add here that seven Europeans and thirteen natives had died of "pneumonia." In 1897 there were nine European deaths and thirty coloured. In the following year (1898) nearly the same proportions were observed. Seventeen out of ninety-nine European deaths were from phthisis, and out of 167 coloured persons forty-seven were from that disease, giving ratios of one in every six deaths of Europeans and one in three-and-a-half of the coloured. In 1899 the disproportion was still greater. Of 101 Europeans five only were from phthisis, one in twenty; and of 148 natives no fewer than twenty-three, or one in six.

In the King William's Town district the coloured population is in very large excess of the European (9,000 of the latter to 78,000 of the former). The town itself has a population of 7,000. The native population is largely engaged in agricultural and pastoral pursuits. As it borders on Caffraria there is, as compared with Malmesbury, less of the Hottentot and much more of the Kafir blood in the coloured population.

From King William's Town we may suitably pass to Albany, not very far distant, and to Cradock and Aliwal North, both places at good elevation and supposed to be very valuable health resorts for Europeans. At Albany we find Dr. Greathead reporting that "an enquiry into the spread of phthisis, more particularly amongst the natives, would be interesting, and might lead to some valuable suggestions for its prevention. Amongst Europeans there were, in 1897, ten deaths, whilst amongst the coloured there were no fewer than sixty-four, yet the coloured population is less than double that of the European (9,000 against 14,000)."

At Cradock, Dr. P. S. de Wet tells us that in 1898, out of 125 European deaths, ten were from phthisis; and out of 281 coloured, twenty-three were due to it. Here we find that the ratios of European deaths and coloured are almost equal—a fact which is to be explained, in all probability, by the circumstance that Cradock has attracted many European invalids. From Aliwal North, a town very similarly circumstanced, Dr. Guillemard sounds a note of warning:—

“Sufferers from phthisis continue to be attracted to Aliwal North from Europe, and it is much to be desired that steps should be taken to prevent the spread of tuberculosis by these invalids.”

From the Middelburg district, which borders on that of Cradock, we have Dr. Holzmann's statement that in 1899, out of a total of 177 deaths, ten were from phthisis. Middelburg town itself stands at an elevation of 4,000 feet, and has a sanatorium; it may probably therefore have increased its mortality by attracting invalids. That we may not weary the reader with citations, we will content ourselves with only one more from Cape Colony itself, and with only a very brief reference to the Native District.

Humansdorp is a large village nine miles from the sea, and not very far from Port Elizabeth, a city second in importance only to Cape Town. The district has a population of about 12,000, of whom two-thirds are coloured. Dr. Coulton, medical officer to the Hankey sub-district of Humansdorp, reported in 1898 that phthisis was very prevalent, fourteen out of fifty-seven deaths in the village and eleven out of forty-three in the district being attributed to it. In 1899 in the whole district including the village there were twenty-four deaths from it out of a total of seventy-six.

Passing still further eastward we come to the district formerly known as Caffraria and esteemed as second to none in South Africa in beauty and salubrity. It is now known as “Native Territory,” being in some sense secured for the enjoyment of the native (Kafir) tribes. Passing from south to north we have the Transkei district, Tembuland and Pondoland. It is to be understood that almost the whole population is coloured. Adjacent to Pondoland is Griqualand East, the population of which is largely the bastard Hottentot. In all these regions phthisis would appear to be common and to be increasing.

In 1899 Dr. T. W. Lee wrote from *Umsikaba* :—

“Consumption, which I noted last year as being very prevalent among the natives, has been corroborated by my experience since. I am quite sure the mortality among them, more especially the children, from this disease is very great.

“Taking into consideration the moist climate, their mode of living in huts into which at night they take care no air shall enter, and from which there is no means of ventilation, then, I say, the prevalence of phthisis among them is not to be wondered at whether it is contagious or not.”

From *Nqamakwe* in Tembuland, from Dr. John Struthers, we have the report :—

“Phthisis is to be met with very frequently, old and young alike suffer, and one may safely predict that tubercle, in its different forms, will account for the great proportion of ill-health in native parts.”

It is everywhere, and always, difficult to obtain statistics which may be trusted, on the subject of tuberculosis. In South Africa up to the present time these difficulties have been exceptionally great. The duties of the district medical officers are discharged in many instances by men of excellent fitness for such posts and zealous in professional pursuits. The data which are supplied to them are, however, very defective, more especially as regards the causes of death in natives. Registration is very imperfect and diagnosis very uncertain. The statements which we have quoted must therefore be received with some caution, more especially where they concern the relative mortality of different districts. They may, however, be trusted to the extent that they imply a lamentable prevalence of fatal lung disease, and that the mortality occurs all over the Colony and falls much more heavily on the coloured than on the white races. There is reason also to believe that this mortality has much increased of late years. There are no statistics to prove this, but it is a general conviction in the minds not only of medical men but of intelligent missionaries and others who have resided long in the Colony. Up-to-date pathogenists will say at once—as a matter of fact they do say—that this increase is due to the importation of British tuberculosis which has been going on for the past thirty years. There are difficulties, however, in the way of accepting off-hand this hypothesis. The intercourse between the natives and European invalids cannot be supposed to have been either intimate or extensive, and it can only have occurred in certain districts. But the spread of tuberculosis amongst the natives has taken place

everywhere and most perhaps in the districts where there are fewest whites. It prevails in the Transkei and Tembuland, which are exclusively native territories. The increase was, if we mistake not, noted with anxiety by Missionaries before the advent of British consumptives and in regions which they have never invaded. By some of them the suggestion has been reluctantly offered that the native has become more susceptible to lung ailments since he has been persuaded to wash his body instead of greasing it, and to wear clothes instead of an occasional blanket. The latter garment was easily thrown aside when wet, whilst under the modern system but too often wet clothing is allowed to dry on the body. The great frequency of pneumonia in the more elevated regions of South Africa may, by some of the less advanced in the contagionist school, be suspected as taking some share. This prevalence is generally admitted, and is attributed by some to dust and dust-contagion, by others to the very frequent and sudden changes in temperature which occur. We observe that Dr. Holding, reporting on this matter from the Maclear plateau (4,000 feet), attributes 60 per cent. of the native mortality to pneumonia. Lastly there may be some suspicion that owing to change of habits, destruction of game, occurrence of rinderpest, &c., the amount of animal food consumed by natives may have been during late years less than formerly. That the tubercle bacillus has not been spread by either eating beef or drinking milk may be taken as certain, for bovine tuberculosis is practically unknown in South Africa.

SEGREGATION IN LEPROSY.

THE results of recent investigations which show that, under certain conditions, leprosy can be spread in families, from person to person, may be expected to increase the zeal of those who advocate legislation for the compulsory segregation of all lepers. Such outcome will be reasonable, but possibly nevertheless much to be regretted. It may be well, therefore, to examine a little closely as to what is meant by segregation; how in detail it is to be accomplished; and what have been the results where it has been carried out. According to one plan the leper is absolutely removed from his

family and shut up in an asylum, or compelled to restrict himself to a hut. This is the kind of segregation often, but most erroneously, supposed to have been the means of suppressing leprosy in the middle ages. It is that which to some extent is now carried out in Cape Colony, and it has been attempted with consistent and almost ruthless rigour in the Sandwich Islands. Miss Bird, who visited these beautiful Islands soon after the decree was promulgated, shall describe for us the methods adopted.

"When the search for lepers was made the natives hid their friends away under mats, and in forests and caves, till the peril of the separation was over, and if they sought medical advice, they rejected foreign educated aid in favour of the highly paid services of Chinese and native quacks, who professed to work a cure by means of loathsome ointments and decoctions, and abominable broths worthy of the witches' cauldron. However, as the year passed on, lepers were 'informed against,' and it became the painful duty of the sheriffs of the islands, on the statement of a doctor that any individual was truly a leper, to commit him for life to Molokai. Some whose swollen faces and goggle eyes left no room for hope of escape, gave themselves up; and a few, who, like Mr. Ragsdale, might have remained among their fellows almost without suspicion, surrendered themselves in a way which reflects much credit upon them. Mr. Park, the marshal, and Mr. Wilder, of the board of health, went round the islands repeatedly in the Kilanea, and performed the painful duty of collecting the victims, with true sympathy and kindness. The woe of those who were taken, and the dismal wailings of those who were left, and the agonised partings, when friends and relatives clung to the swollen limbs and kissed the glistening bloated faces of those who were exiled from them for ever, I shall never forget.

"There were no individual distinctions made among the sufferers. Queen Emma's cousin, a man of property, and Mr. Ragsdale, the most influential lawyer among the half whites shared the same doom as poor Upa, the volcano guide, and stricken Chinamen and labourers from the plantations. Before the search slackened between three and four hundred men, women and children were gathered out from among their families and placed on Molokai."

In one instance at least a leper defended himself and killed several of the sheriff's men before he could be taken.

Yet the result of a more than twenty years' trial has, we believe, proved a failure, and leprosy is as rife as ever.

The same plan has, according to the testimony of Mr. Cantlie, been tried for many centuries in China and with no good result. The supply of lepers is still kept up, and neither increase nor decrease in their numbers can be alleged. Mr. Cantlie's words are: "I am not aware that there are fewer lepers in China now after many hundred (it may be thousand) years of segregation." In China there is a leper village in almost every district, and those who

are diseased are compelled to go and live in them. Yet Mr. Cantlie continues: "The leper villages are still being fed and maintained, and it may be the number of their occupants is increasing." In answer to a query, "Are the Chinese afraid of people who have the disease living with them?" the answer was, "Yes! they would not allow a leper, even if the son of rich parents, to remain in their neighbourhood." The segregation which was carried out in Europe in the middle ages was something far less complete than that adopted in China. It was irregular and incomplete at the best, and in many districts in which nevertheless the disease died out, it was probably not even attempted.

Norway is the place which is most frequently quoted as affording proof of the efficacy of isolation methods. Yet the statistics here are by no means clear, and the kind of isolation attempted falls much below the standard of what most of its advocates think needful. So long ago as 1856 it was claimed that under isolation methods leprosy had diminished 50 per cent. Yet it is most certain that at that time, and long subsequently, lepers were to be seen selling fruit in the streets of Bergen, and although a most praiseworthy effort had been made by the Government to induce them to reside in the hospitals which had been provided, there was no compulsion exercised. In 1890, the latest year of which the statistics are before us, there were in Norway 447 lepers living at their own homes, whilst not many more were under care in the hospitals (507). Dr. Hansen writes respecting this home isolation: "All that is wanted is cleanliness, both personal and in the household"; and although he adds, it is true, that "amongst people where leprosy prevails it is almost impossible to get sufficient cleanliness thoroughly enforced," it would appear from the facts that much confidence in that direction is entertained in Norway.

The present condition of things in Norway is sufficiently indicated by the following passage:—

"We think, therefore, that the best measures are those which have been taken in Norway, where the lepers are isolated at their own request, and where the communities can get rid of the disease, if they will, since the sanitary authorities have the power to order the leper to live sufficiently isolated from his family, and if he cannot or will not assent to this, can compel him to enter an asylum."¹

¹ "Hansen and Looft on Leprosy," p. 124 (1895).

Again we have, "Since the State pays all the expenses of the lepers in the asylums, their families are generally relieved by getting rid of the lepers, who are almost invariably bad workers and unable to earn their living." It is clear from these expressions that even up to the present time isolation in Norway is to a large extent optional. As we have seen, one-half of the Norwegian lepers are still at their homes and are subject only to such restrictions as their friends or the parish authorities may incline to enforce. That these restrictions will vary in different places and with patients in different positions in the social scale may be easily understood. Probably they do not, as a rule, go the length of separating man and wife.

It is obvious, then, that Norwegian segregation differs very widely from that which was carried out in the Sandwich Islands some years ago and which is now attempted in South Africa, and it is very necessary to bear this in mind when the supposed success of segregation measures in Norway are urged as an argument for the adoption of others of a quite different scope in other lands. It is one thing to attract the poor, decrepit leper into a comfortable asylum and to secure the co-operation of his friends by offering to relieve them of the cost of his support, and another to adopt such measures as Miss Bird describes.

The enforced and lifelong separation of the sexes, which is carried out at Molokai, on Robben Island and at Emjanyana, is one of the miseries which is most severely felt. To this Father Damien himself bears testimony.

Father Damien himself wrote:—"In the fulfilment of my duties as priest, being in daily contact with the distressed people, I have seen and closely observed the bad effect of forcible separation of the married companions. It gives them an oppression of mind which in many instances is more unbearable than the pains and agonies of the disease itself. This uneasiness of the mind is in course of time partly forgotten by those unfortunates only who throw themselves into a reckless and immoral habit of living. Whereas, if married men or women arrive here in company with their lawful mates they accept at once their fate with resignation, and very soon make themselves at home in their exile. Not only is the contented mind of the leper secured by the company of his wife, but the enjoyment of good nursing and the assistance so much needed in this protracted and loathsome disease."—"Father Damien," by Edward Clifford.)

This is a matter which possibly in Norway is not felt to be urgent, but it is one which all who have had to do with the warm-blooded inhabitants of tropical lands are compelled to recognise. It

is the enforced recognition of this difficulty which, chiefly, has led, in some places, to the establishing of villages into which not alone the leper, but his wife and family, shall be admitted. This is the plan at present under the contemplation of the Natal Government. The objections to it on the supposition that the disease is either hereditary or actively contagious are obvious, as is also the suggestion that it must be very costly. It is, however, the only form of segregation which would be there practicable. Any attempt to seize upon and deport individual lepers would only lead to their migration or concealment.

In all discussion as to segregation it must be kept in mind that it does not strike at the root of the matter. It leaves the cause of leprosy, whatever that may be, untouched, and merely endeavours to prevent spreading from person to person. It may be that—after all that must now be fully admitted—this kind of spreading takes but a very small share in the production of leprosy. When we are told that in Norway leprosy is diminishing as a result of the isolation measures there adopted, we cannot but remember that it is now rapidly dying out in Madeira, where no such measures are adopted, and that it has under like conditions of entire neglect of isolation wholly disappeared from numberless other places.

OUR NEXT DINNER.

THE date of the next Polyclinic Dinner has been fixed for Thursday, June 5.

The Right Hon. H. H. Asquith, K.C., has kindly consented to take the chair.

The Dinner Committee consists of the following gentlemen:—Dr. C. Theodore Williams (*Chairman*), Sir William Kynsey, Mr. Jonathan Hutchinson, Mr. Reginald Harrison, Mr. E. Vaughan Morgan, Mr. A. Phillips, Mr. Dallaway, Dr. Tilley, Captain Pinch (*Hon. Treasurer*), Mr. L. Cheatle and Mr. H. R. Walker (*Hon. Secretaries*), with power to add to their number. A long list of Stewards has already been enrolled, and the Secretaries will be glad to receive the names of any gentlemen who are willing to act in that capacity. The Dinner will take place at the Criterion, and with so distinguished a chairman, should be largely attended.

NOTICES.

A Meeting of the *CANCER Committee of Investigation* will be held on Thursday, April 24, at 5.30, in the Council Room (open to all).

Business.—Nomination of Members of Committee (for approval by the Council).

Subjects for Discussion.—(I.) The influence of Race upon the occurrence of Cancer; (II.) Has the age of the parent at the time of procreation any influence on the inherited tendency to Cancer?

A Meeting of the *VACCINATION Committee of Investigation* will be held on Thursday, May 1, at 5.30, in the Council Room (open to all).

Business.—Nomination of Members of Committee (for approval by the Council).

Subjects for Discussion.—(I.) The best method of protecting Vaccination Sores; (II.) Cases of insusceptibility to Vaccination.

LEPROSY CURED BY AN ATTACK OF SMALLPOX.—The following facts were supplied to me some years ago by Mr. T. M. Nair, a native of Malabar, and then a medical student in Edinburgh:—"A gentleman in Malabar who had certain symptoms of leprosy, and who was well known throughout the place as a leper, had a severe attack of smallpox. After a period of more than a month he recovered from his smallpox, and curiously enough the symptoms of leprosy that he had also disappeared. From that time, till his death the other day, he never had any symptom whatever of leprosy."

* * *

IMMUNITY OF CERTAIN INDIANS FROM LEPROSY.—Can any of our readers confirm, or otherwise, the following statements. They were made by Dr. Milroy:—"The immunity of the aboriginal Indian tribes still living in the district of Essequibo, and also of the descendants of former Dutch settlers by Indian women, known by the term of 'Bovianders,' was frequently mentioned to me, and the reason generally assigned was that these primitive people lived chiefly on fresh fish from the river, and game caught in the woods, along with cassava meal, and other roots, &c., and only occasionally ate the salt fish which is the staple food of the Negroes. Mr. Allison, of Mahaica, has remarked that during eight years' experience in the colony he had never seen or heard of an aboriginal Indian having been afflicted with leprosy."

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON COXA VARA.

BY A. H. TUBBY, M.S., F.R.C.S.

[*Abstract.*]

COXA VARA is a condition which, though recognised for some considerable time, has only recently received adequate attention and discussion. It may be defined as a depression of the head and neck of the femur resulting in a diminution of the angle which these form with the shaft of the bone. The neck is bent from its normal oblique direction towards, or actually into, a horizontal line, so that, instead of forming with the shaft a large obtuse angle, its junction with the shaft produces an angle approximately of the dimensions of a right angle or even less. This depression of the head and neck of the bone is usually also accompanied by a bending forwards or backwards of the neck, so that this becomes convex either on the anterior or posterior aspect. The term coxa vara, therefore, strictly speaking, means a certain definite deformity of the head and neck of the femur in relation to the shaft of the bone. Its use, however, is commonly restricted to cases in which this deformity results from softening of the bone, and thus, as generally employed, the term does not include cases in which the deformity is congenital or those in which it results from tubercular disease or from traumatism. A so-called "false coxa vara," the result of an outward bending of the upper part of the shaft of the femur, must also be excluded.

The disease coxa vara—using the term in the clinical sense above defined—is an affection of adolescence rather than of childhood, the most usual time for its manifestation being from the tenth to the

twentieth year. Its most frequent cause is rickets, and it may be regarded as a late result of that disease. Though rickets is frequently discussed as a disease limited to the early years of life, there is good reason to believe that this is too restricted a view, and that the symptoms of rickets may occur in successive outbreaks spread over the periods of childhood and adolescence. The earliest evidences appear in the shape of the well-known deformities of the bones; later, say from the sixth to the twelfth year, there is a tendency to scoliosis; about the twelfth year rickets inclines to express itself in the form of flat-foot; and from that date to the twentieth year or so, it may produce coxa vara. Rickets must be placed as the most common cause of coxa vara, though other changes associated with softening of the bones, as ostitis, osteomyelitis, ostitis fibrosa, and osteomalacia, have also to be included among its antecedents. In reference to sex, coxa vara is more common in boys than in girls. It is more often unilateral than present on both sides, and in some instances it appears to be associated with excessive standing or walking.

The symptoms of coxa vara are largely to be attributed to the altered position and inclination of the head and neck of the femur. This necessitates a modification of the direction of the axis of the shaft, which becomes more decidedly slanted inwards, so that the internal condyle of the lower end of the femur is rendered relatively prominent, and if both sides are affected, there will be a considerable degree of genu valgum. Indeed, in many cases which receive the name genu valgum it is highly probable that there is a downward bending of the neck of the femur, and at least in some instances this is almost certainly the first and causal condition. The increased inward slant of the femur in coxa vara receives its most striking demonstration in bilateral cases, where the lower ends of the bones tend to overlap, and there is produced the so-called "scissor-leg" deformity, the gait in these circumstances is waddling in character, and more or less lordosis is present. In unilateral cases there is some shortening of the affected limb, ranging from half to one and a-half inches in different patients; as a consequence of this there is tilting of the pelvis, which falls towards the affected side; and as a further result there may be some lateral curvature of the spine. Another sign of the altered position and inclination

of the neck of the femur is a relative prominence and elevation of the great trochanter, whilst the foot will be inverted or everted according as the neck is bent with a posterior or anterior convexity respectively. Yet again, the inward direction of the shaft of the bone gives the adductor muscles an advantage, and as a consequence, partly of this, and partly of the osseous deformity, there is restriction of the range of abductor movement. This is a most important sign of coxa vara, and both it, and some other of the above-mentioned facts, are best appreciated when the patient is placed in the recumbent position with the thigh fully flexed on the abdomen. In reference to this latter position, it is necessary to note that a considerable backward curve of the neck of the femur will prevent to a greater or less extent complete flexion of the thigh, and this establishes occasional difficulty in the diagnosis between coxa vara and hip-joint disease. In both conditions there is pain at the onset, shortening (or apparent shortening), elevation of the trochanter major, and adduction. In hip-joint disease the pain is more constant, and there are liable to be sudden, painful muscular startings during sleep; real shortening only occurs when the head of the bone is dislocated; and there is depreciation of the general health. Movement at the joint is limited in all directions, whereas in coxa vara the limitation affects abduction only, unless there is a forward curve of the neck of the bone, when flexion is also restricted. Coxa vara is not attended by general constitutional symptoms, and its deformity may be recognised by means of the X-rays. This latter method is also a ready means of distinguishing coxa vara from congenital dislocation of the hip. In this the history of abnormal gait can be traced back to the date when the child commenced to walk; there is no limitation of movement unless in an old-standing case—on the contrary, there is an abnormally free range of movement; the head of the bone is absent from its natural position and can be detected in an abnormal situation, more especially when the limb is forced upwards; and there is the “telescoping” movement.

The treatment in early slight cases of coxa vara includes general constitutional measures, rest in bed, and extension with full abduction of the limb. In these cases the question arises as to when the patient shall be allowed to get up. The safe rule is to

observe the date at which extension ceases to produce further elongation of the limb. It may then be concluded that the osseous tissue in the neck of the bone has become strong and firm, and, to make the position quite secure, the patient should be kept in bed for another four weeks. When shortening of the limb is present to the extent of three-quarters of an inch, and there is adduction, it may be necessary to tenotomise the adductors, this being followed by extension and abduction. If these measures fail there remains osteotomy. The best position for this is obliquely through the trochanter major. It is a more difficult operation than section through the neck or through the shaft below the trochanters. But it gives large surfaces for the formation of a firm union, and it does not leave any considerable measure of deformity. After division of the bone the limb is fixed to an abduction splint at an angle of 45° .

ON GONORRHOEAL ARTHRITIS.

BY W. H. A. JACOBSON, M.Ch.

[*Abstract.*] .

THE case which formed the text for Mr. Jacobson's lecture was that of an unmarried man, 25 years of age, who in November, 1901, placed himself under medical treatment in consequence of an affection of his right wrist-joint. The condition was at first regarded as rheumatic, and later, in view of the failure of salicylates and various local measures, was diagnosed as gout. In criticising these successive conclusions, Mr. Jacobson remarked that an acute or sub-acute inflammatory attack limited to one joint was a clinical fact that in itself ought always to give rise to a suspicion of gonorrhœal arthritis, this being more particularly true when the patient is a young and unmarried man. Further, the character of the joint affection in the case under discussion was emphasised as strengthening such a suspicion, and as much more decidedly suggestive of gonorrhœal arthritis than of rheumatism. There was not, as in the latter affection, effusion into the joint cavity. On the contrary, the condition was one of thickening of the joint capsule

and of the peri-articular tissues, which is one of the recognised forms of gonorrhœal joint affection. The failure to recognise the suggestion attending these facts had led to a serious error in diagnosis and to a consequent postponement of suitable treatment. For though the patient denied that he had at any time suffered from gonorrhœa, pressure along the urethra caused a drop of pus to appear at the meatus and thus placed the diagnosis entirely beyond doubt. The facts of the case, therefore, carried the obvious clinical lesson that evidences of inflammation limited to a single joint ought to suggest the possibility of gonorrhœa to the medical attendant. The suggestion is all the stronger when the joint affected is outside the usual incidence of such affections as gout or rheumatism. The temporo-maxillary joint, the sterno-clavicular joint, and the sacro-iliac synchondrosis, are examples which may be quoted in illustration of this statement. In some instances of gonorrhœal arthritis it is true that symmetrically situated joints on opposite sides of the body are simultaneously affected; in others, whilst one joint is conspicuously attacked, its fellow is involved to a lesser degree; but in many, probably the majority, obvious evidences of the disease are found only in a single joint. The affection is frequently, as in the case just described, one of capsular and periarticular thickening—a condition usually seen in the wrist and elbow; and this form is quite as common in women as in men. The other variety is that of synovial effusion, and is met with, for the most part, in the knees, ankles, and shoulders.

The suspicion to which any of the above-described events give rise is converted into certainty by the discovery of a gonorrhœal discharge. The patient may repudiate the suggestion, but the necessity for an examination should be explained as a matter of great importance, and a refusal can hardly admit of other than one interpretation. In making such an examination there are certain opportunities for error which must be borne in mind. Thus in the male sex the purulent stage may have terminated, and hence nothing be detected beyond the presence of a slight gleety discharge, as gonorrhœal arthritis rarely develops before the third week and may be postponed for several months after the onset of the urethritis. It needs time for the gonococci to get past the constrictor urethræ muscle to reach the deeper parts of the urethra

and to enter the glandular tissues of the prostate, where, not being washed out by the act of micturition, they gain the opportunity to enter the circulation. Possibly in some instances the agent causing the arthritis is not the gonococci, but their toxins. In any case, however, arthritis is not an early complication of gonorrhœa, and hence, when it occurs, the purulent discharge may have ceased. In women there is, of course, great need for caution in raising the suspicion of a possible connection between the existence of an inflamed joint and the presence of a vaginal discharge. The woman may be an innocent victim, she may be quite unaware of the significance of such a discharge, or she may regard it merely as the repetition or aggravation of a leucorrhœa from which she has previously suffered. Hence, in all good faith, she may make inaccurate statements. Even an examination may give negative results unless it is remembered that the gonorrhœal discharge does not, as a rule, persist in the female urethra, and that in the adult, at least, this statement is equally true of the vagina. It is in the glands of Bartholin and in the canal of the cervix uteri that the continuing evidences of gonorrhœa are to be found.

The prognosis of gonorrhœal arthritis varies according to the stage at which the case comes under observation. If seen early and treated on proper lines, the prospects of the joint are decidedly good. Neglected cases, on the other hand, have a somewhat serious outlook. The condition tends to ankylosis, and when this has occurred and there is in addition much muscular wasting, the prognosis must be a most guarded one. The existence of a rheumatic taint in the patient is a factor which increases the probability of imperfect success in treatment.

The cardinal principles of treatment are three in number. These are fixation of the affected joint combined with gentle pressure over it; the stopping of the discharge; and the improvement of the patient's general vitality and vigour. The first is best accomplished by plaster of Paris. In an acute case it may be necessary to put the patient under an anæsthetic; the bony prominences, as there is often much muscular wasting, should be carefully padded with cotton wool, and then the plaster applied so as to completely fix the part and to exercise moderate pressure over it. The plaster will probably need renewing every four or five days, and when it is finally

removed, a Martin's rubber bandage should be applied. In the case of the wrist, the plaster splint should never be carried beyond the line of the metacarpo-phalangeal joints, so as to secure freedom of movement of the fingers. The treatment of the discharge must vary according to the stage of the gonorrhœa. Speaking on the general question, Mr. Jacobson said that the agent used for injection was of much less importance than the manner of using it. For the first few days of a urethritis he prefers to use boiled water; afterwards he orders Watson Cheyne's bougies, one to be introduced and retained for half an hour twice daily. Saline purgatives may be needed at the outset, but by the time arthritis has developed the patient's vitality has become seriously depressed, and the medicines required are tonics, such as cod-liver oil, hypophosphites, and strychnine.

The practice of active surgical measures on joints affected with gonorrhœal arthritis is rarely necessary, though obstinate persistence of synovial fluid may demand paracentesis or incision. In the variety characterised by capsular and pericapsular thickening, the extension of the condition along the limb sometimes leads to surgical error; the condition is mistaken for cellulitis, and is incised. The great majority of cases need no heroic measures. Provided only the nature of the case is early recognised and the treatment as above defined is promptly adopted, the prospects in gonorrhœal arthritis, text books to the contrary, may be presented in fairly cheerful and confident terms.

ON HÆMORRHAGES OCCURRING AT OR ABOUT THE MENOPAUSE.

BY M. HANDFIELD-JONES, M.D., F.R.C.P.

[*Abstract.*]

THE lecture was devoted to a discussion of the statement that it is a frequent event to find the period of the menopause characterised by hæmorrhages of a functional nature and independent of organic disease in the uterus and its appendages. In order to test the accuracy of this proposition, the lecturer presented a critical analysis

of his own experience, extending over several years, and including all those cases where the patients had complained of excessive loss attributed more or less confidently to a disturbance natural to the period of the climacteric. From these cases he isolated a group in which an obvious gross lesion, such as carcinoma of the cervix, a considerable fibroid, etc., was easily detected. There then remained a large number where the cause of the hæmorrhage was not so readily explained. Here, if anywhere, ought to be found the material to justify the view that at the menopause frequent and excessive hæmorrhage is to be expected in the natural order of things. Yet on analysis it was discovered that, with one or two doubtful exceptions, every one of the so-called functional hæmorrhages could be referred to a definite though perhaps relatively slight structural cause, and upon the removal of which the hæmorrhage ceased. Among these causes were to be found such conditions as small polypus of the cervix, fungoid hypertrophy of the uterine mucosa, multiple adenoma of the same structure, retroversion of the uterus, and the early development of carcinoma or sarcoma. These facts therefore directly opposed the widely-accepted view that hæmorrhages at the menopause are of little moment and generally mean nothing more than the impending cessation of the menstrual function. It was urged that this conclusion is one of considerable importance, and that it is necessary to educate the profession, and indirectly the public also, on this matter. The present position leads women suffering from excessive loss at any period about middle life to interpret their symptoms as natural to their age, and so to postpone seeking medical advice. In this way a certain number of patients allow malignant disease to advance to a stage where operation affords little or no prospect of success. If cancer is to be detected in the early stage it is necessary to dissipate the delusion that irregular and excessive hæmorrhage is the natural and proper note of the menopause. In reference to cases in which such hæmorrhages occur and yet cease sooner or later without treatment, it is reasonable to surmise that in at least some of these there is a polypoid hypertrophy of the mucous membrane, and that as this undergoes shrinking along with the general atrophy of the uterus, the hæmorrhage spontaneously comes to an end. The lecture was illustrated by a number of pathological specimens showing various conditions of the uterus leading to abnormal menstrual loss.

ON GENU VALGUM.

BY C. A. MORTON, F.R.C.S.

[*Abstract.*]

MR. MORTON'S lecture was an argument in favour of the thesis that the condition of genu valgum is due, not to a curvature of the lower end of the femur and to an elongation of the inner condyle of that bone, but to a deformity—a curvature with the convexity inwards—of the tibia, which may or may not be accompanied by a corresponding change in the line of the fibula. Upon this conclusion he based his advocacy of the practice of osteotomy, not of the femur, but of the tibia, and he related a number of cases and showed photographs and skiagrams of patients on whom he had successfully practised this operation. Admitting that in certain instances there was some elongation of the internal condyle of the femur, he disputed the suggestion that this is sufficient in itself to account for the fact of genu valgum, and he considered such elongation might be due to a diminution of pressure on the internal condyle as a result of an alteration in the direction of the transmission of the weight of the body, consequent on the abnormal curvature of the tibia. The elongation of the internal condyle, when present, was thus placed as a secondary, and not as a primary fact of the condition. In reference to the operation necessary for the correction of the deformity, Mr. Morton allowed that osteotomy of the femur, according to Macewen's method, certainly secured this end; but he argued that it at the same time produced obliquity of the line of the knee-joint, and that unless there was displacement of the lower end of the femur after the operation, there was necessarily a change in the direction of the transmission of pressure through the bones of the lower limb. It is more reasonable to operate on the bone, viz., the tibia, which is the actual site of an abnormal curve, and, by correcting this, to remove the genu valgum for which it is responsible. Hence the proposal to remove a wedge of bone from the upper part of the tibia. The wedge should lie, not transversely, but obliquely, with the apex directed

upwards and outwards. The special risk of the operation is the danger of injuring the posterior tibial vessels and nerve, and hence the separation of the wedge at the posterior part must be conducted with considerable care. It is only necessary in occasional cases to divide the fibula, and when this is demanded, it is best performed in the lower third. The limb, after operation, is fixed on a long splint, with a back splint for the leg and provided with a travelling foot-piece moving in a transverse slot, so as to allow the foot to be fixed in a suitable position.

Mr. Morton concluded his lecture by a reference to the use of splints in the treatment of genu valgum, and by a discussion of spontaneous rectification of the deformity. He mentioned several recorded cases of spontaneous disappearance of the deformity and described one under his own care. He expressed considerable doubt as to the possibility of splints, as used in ordinary out-patient practice, moulding the bones into better position, but thought such moulding was possible under certain conditions. Splints might be very useful as supports, and in some cases as a means of keeping children off their feet. With regard to the question of operation, he pointed out the liability to relapse if operations were done in young children, but if the deformity was marked and there was reason to think the stage of softening and yielding of the bones was over, then osteotomy might be done. In older children and young adults, if the deformity is marked, and not increasing, then osteotomy should be performed, and osteotomy of the tibia (and if necessary of the fibula) rather than of the femur, unless a skiagraph showed that the genu valgum was due chiefly to a change in the lower end of the femur—a condition which Mr. Morton had not observed.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY GUTHRIE RANKIN, M.D., M.R.C.P.

Tuesday, March 18, 1902.

A Case of Dilated Stomach.

THE patient, a woman of 22 years, showed all the physical evidence of considerable dilatation of the stomach. The history of dyspepsia and vomiting of large quantities of sour fluid extended over five years, but it was impossible to find any definite proof of obstruction at the pylorus. There was no sign of a tumour, and no history decisive of a gastric ulcer, which by its cicatrisation might have led to narrowing of the pyloric opening. Hence it appeared necessary to assume that the dilatation was the result of muscular atony, probably dependent on chronic dyspepsia. Considerable improvement had been effected by daily lavage, the use of peptonised food, nutrient enemata, and galvanism. On two occasions the passage of the stomach tube had been followed by slight attacks of tetany.

Formaldehyde Injections in Phthisis Pulmonalis.

Dr. Rankin showed two patients, the subjects of phthisis pulmonalis, who had for some weeks been under treatment by the intravenous injections of formaldehyde according to the method suggested by Dr. Maguire. A demonstration of the mode of administering the injection was given. The fluid employed is obtained by dissolving formaldehyde in a 6 per cent. solution of sodium chloride. At first the strength of the injection should be 1 in 2000, and of this 50 cc. may be given daily. By gradual steps the percentage

had been increased in the cases presented to 1 in 700, and the dose of this to 80 cc. These doses had produced no unpleasant effects, and it was intended to push the treatment still further.

Dr. Rankin also alluded to the success of the roof shelters which have been adopted at the Seamen's Hospital, Greenwich, for the treatment of pulmonary phthisis. He suggested that the same plan might be adopted at other hospitals and at the poor-law infirmaries. This would secure, with but small expense, the opportunity of giving a large number of consumptives the benefits of the open-air treatment. The present disposition seemed to be in the direction of multiplying sanatoria—a very expensive proceeding, more particularly in view of the consideration that it is by no means certain that sanatorium treatment is to be the last word in the curative management of phthisis pulmonalis. By slight modifications of, or additions to, many existing hospitals, most of the advantages of the out-door method might be secured. A large number of patients could thus be promptly treated in circumstances giving every opportunity for exact observation. The consumptive poor would get the benefits of the treatment, and the method would be subjected on a considerable scale to the criticism and scrutiny of a large number of competent and impartial observers.

Other patients included (1) a case of functional nervous disease; (2) a case of beri-beri showing the evidences of peripheral neuritis; (3) a man of 49 years with a history of two attacks of temporary unconsciousness and the subject of chronic albuminuria; (4) a child with rickets and gastro-intestinal symptoms.

SURGICAL CASES.

BY J. JACKSON CLARKE, F.R.C.S.

Wednesday, February 28, 1902.

Cancer of the Rectum.

MR. JACKSON CLARKE showed a man, aged 59 years, from whom he had removed five inches of the rectum two years and ten months ago, and subsequently closed a defect left by the operation. The patient was now in perfect health and had good power in the

sphincter. For cancers of the rectum that were just within reach of the finger Mr. Clarke thought that the operation he had used, a modified Kraske, was an excellent one, and indeed it constituted one of the most striking improvements in the surgical treatment of cancer during late years. Many careful observations had to be made before deciding that the operation was feasible, and by careful selection of cases only were disappointments to be avoided. When the patient's bowel could be cleared by aperients it was unnecessary to do a preliminary colotomy. When the peritoneum was opened on each side of the rectum it was easy to ascertain whether there was anything to contraindicate proceeding further. Adhesions to the bladder, to the small intestines, or over the iliac veins, or general infection of the pelvic cavity, were the chief conditions that made it unwise to complete the operation ; but if any such were found the sacral wound could be quickly closed and an inguinal colotomy done.

BY JONATHAN HUTCHINSON, JUNR., F.R.C.S.

Thursday, March 6, 1902.

A Case of Chancre of the Lip.

THERE was no room for doubt as to the nature of this case, for in addition to the sore on the lip there was a typical enlargement of neighbouring lymphatic glands, and also a highly characteristic skin eruption. Each of these three clinical facts presented some opportunity for comment. Thus the whole extent of the upper lip was greatly thickened and swollen, a condition said to have been present for some seven weeks. On the other hand, the actual chancre was represented only by a small granulating surface about the middle of the lip. Whilst the swelling generally was firm, there was no appreciable localised induration at the base of the ulcer. It was pointed out that the combination of events just described is not infrequent in chancre of the lip. The actual sore may be very small and may be entirely unattended by induration—a remark which may be made, indeed, of all extra-genital chancres. If untreated, however, there may after a time be considerable swel-

ling in the neighbourhood, and thus, unless care is taken, the true nature of the case may be overlooked. The feature of main interest in connection with the lymphatic enlargement was the very considerable size of the glands in the submaxillary and carotid regions. These "giant" buboes are not uncommon in association with extragenital chancres, and they are sometimes very persistent. The skin eruption was a mixed macular and papular one. Mr. Hutchinson, from careful observation and analysis of over 100 cases of primary syphilis, was in a position to state that in 60 to 70 per cent. the earliest eruption of secondary syphilis is wholly, or in part, papular, and that, when erythematous, papules are often present at the same time.

In connection with this case a number of drawings were exhibited, showing chancres in unusual situations. A case was mentioned in which a primary sore was present on the scalp, a second in which the sore existed on the heel, and a third where the male nipple was the site of infection. Another point discussed was the possibility of auto-inoculation from a chancre. This is sometimes denied, but Mr. Hutchinson exhibited a photograph showing a large sore on the lower lip and a smaller one (which appeared six weeks later) at a corresponding point on the upper lip. He also quoted the case of a patient who from a chancre on the penis infected his index finger at the end of two months, the sore in the latter situation being followed by the appearance of a large axillary bubo with indurated lymphatic cords running up the arm.

A Case of Persistent Tertiary Syphilis.

The patient, a woman, acquired the disease some twelve years ago. She is now, and has been for years, the subject of a persistent glossitis, which exhibits itself in the form of ulcers on the sides of the tongue, and smooth patches on the dorsum. In addition, the left hand shows two considerable patches of palmar psoriasis; the well-defined, crescentic margins, and thickened character of the scales, are seen in characteristic fashion. A similar condition is present on the sole of the right foot. A point of some moment is that these patches are very itchy. Syphilitic eruptions, it is true, as a rule are unattended by itching, but to this rule, late squamous eruptions often provide an exception.

A Case of Dental Cyst.

The patient, a woman of 32 years, complained of a swollen condition of her right cheek. The swelling was first observed two years ago and had only very gradually increased in size. These features at once excluded the possibility of malignant disease, as both carcinomata and sarcomata in this situation are invariably marked by rapid development. Further, the swelling had been punctured from the inner surface of the cheek, and some clear, yellow, non-purulent fluid withdrawn. The case, therefore, was not an ordinary empyema of the antrum. Other facts tended to show that the cavity of the antrum was not the actual site of the swelling. Thus, there was no bulging of the floor of the orbit, of the hard palate, or of the lateral wall of the nose. And palpation of the swelling detected, not the "eggshell crackle" suggestive of protrusion of the thin anterior wall of the antrum, but a firm, bony wall covering the lower part, with a soft, fluctuant character above. Mr. Hutchinson, on the basis of these facts, expressed the opinion that the swelling was probably a dental cyst originating in connection with a carious tooth. Such cysts are of somewhat obscure nature, but they probably result from a chronic periostitis associated with disease of the roots of the teeth. The periosteum, which is the wall of the cyst, forms a certain amount of bone, and hence gives some portion of the swelling a firm, resistant character, leaving the other part, as here, soft and fluctuant. The treatment is to remove the diseased tooth and to incise and scrape out the cyst. An alternative diagnosis to the above is that of dentigerous cyst, due to a retained and possibly misplaced tooth.

Other cases included (1) an example of "funnel chest" (*see* POLYCLINIC, vol. ii., p. 262); (2) a young woman the subject of recurring erythema of the face; (3) a case of synovitis of the shoulder joint; (4) a youth with swelling of the testicle and thickening of the vas deferens.

Thursday, March 20, 1892.

Excision of the Gasserian Ganglion.

THE patient, a man of 60 years, had had his right Gasserian ganglion excised for the relief of intense neuralgia in the area of the fifth cranial nerve. Since the operation he had been quite free from pain, and now has no complaint to make other than of some sense of numbness in the right cheek. Attention was drawn to the atrophy of the right temporal and masseter muscles, the result of the injury inevitably inflicted on the motor root of the fifth nerve in the removal of the ganglion. In spite, however, of this atrophy of the muscles of mastication on one side, the patient—and this is the usual experience—does not experience any difficulty in chewing his food, whilst the relief from the agonising pain, which had previously rendered his life a misery, is complete. The history of the neuralgic seizures extends over several years. At first the pain, as is usually the case, was confined to the region of the lower jaw (inferior maxillary division of the fifth nerve). It continued in spite of the removal of the stumps of the teeth, but it was relieved—at least for some months—by two successive operations undertaken for the excision of a portion of the inferior dental nerve. Just, however, as in other cases, resection of the nerve trunk—and the same is true of mere division of the nerve and of nerve stretching—proved only a means of giving temporary relief. The pain returned, and now involved the superior as well as the inferior maxillary division of the nerve. In these circumstances it was decided to offer the patient the prospects afforded by operation for removal of the Gasserian ganglion. The severity of his suffering made him readily accept this, and the operation was performed, with the above-described result.

In speaking of the operation Mr. Hutchinson expressed his decided preference for the method of approaching the ganglion by trephining the skull in the temporal region, rather than for operations in which the skull is opened from below, that is, in the zygomatic fossa. He believed it to be inadvisable to attempt to remove the part of the ganglion which is connected with the ophthalmic division of the nerve. The pain does not involve this

portion of the nerve in more than one out of three cases, nor does it develop here when the lower portion of the ganglion has been removed. Moreover, an operation which includes excision of the ophthalmic division of the nerve close to the ganglion, introduces the chance of opening the cavernous sinus and of injuring either the third or the sixth cranial nerves; it also means the risk of ulceration of the cornea and possibly the compulsory removal of the eyeball. As there is no advantage to compensate for these dangers, it is sufficient to remove the portions of the ganglion connected with the superior and inferior maxillary divisions of the nerve, and to leave the ophthalmic division of the nerve unharmed. The operation, considering its serious nature, is attended with but little shock, and is only followed by such deformity as is produced by a unilateral atrophy of the muscles of mastication. It has been stated that the mortality is as high as 25 per cent., but this includes the results of the earlier methods in which the procedures adopted were more or less experimental. Mr. Hutchinson briefly quoted six cases on which he had operated without a single fatality, and said that Mr. Victor Horsley and Mr. Ballance had had equally good results. The operation should be reserved for cases of intense epileptiform neuralgia where other measures fail to give relief, and where, in consequence, the patient will probably either commit suicide or become a morphinomaniac. When a case is recognised to be of this nature the sooner operation is adopted the better. Experience shows that operative treatment ought not to be too long delayed, and it is practically certain that it will afford permanent relief.

A Case of Inguinal Hernia.

The patient was a man of 60 years with a small but irreducible inguinal hernia, and the practical question was whether the case was suitable for operation with a view to radical cure. The age of the patient might be said to establish a presumption against operation. On the other hand, he was a vigorous man, looking much younger than his reputed age, and he had a clean record in reference to alcohol, and was free from all evidences of bronchitis—the latter two points being matters of prime importance in reference to operative proposals on those who have reached or

passed middle life. Further he was at present going about with the serious risk attached to the pressure of a truss on an irreducible hernia. In these circumstances Mr. Hutchinson advised that the operation should be undertaken.

Sub-Astragaloid Amputation of the Foot.

This patient was shown a year after operation for the purpose of illustrating the good results attending amputation of the foot below the astragalus. Mr. Hutchinson pointed out that this method gave a stump provided with a broad firm pad consisting of the original tissues of the heel on which the patient had been accustomed to walk. This pad did not, as was sometimes stated, show any tendency to atrophy. Nor was there any danger of the flap sloughing shortly after the operation. In some of these respects the operation compares favourably with Syme's amputation. It also gives a longer stump than Syme's method, with a broader support to rest on, and a better purchase for the attachment of an artificial foot; there is also the advantage that the ankle joint is retained. The astragalus too, it may be noted, retains its position and does not undergo any subsequent tilting as is frequent after Chopart's operation. Mr. Hutchinson advocated the sub-astragaloid method as the routine operation in amputation of the foot.

An Inflammatory Swelling in the Upper Arm.

A man of 30 years presented himself with a firm, tender, movable swelling over the brachial artery in the upper arm, with œdema of the forearm, and enlargement of the lymphatic glands in the axilla and supraclavicular region. There was no history of syphilis, and none of any sore or irritation of the fingers. There could, however, be no doubt that the swelling in the arm was inflammatory. It was very tender and had been present some five or six weeks. Mr. Hutchinson referred to cases of abscess formation long after disappearance of the original cause of irritation, and expressed the opinion that, if syphilis could be excluded, the most probable explanation of the present case was a slow lymphatic infection originating in some small breach of surface on the hand or fingers. He advised complete rest for the limb and the local use of belladonna fomentations, but he expected that operation would have to be resorted to.

BY W. H. A. JACOBSON, M.C.H.

*Thursday, February 27, 1902.**A Case of Intra-Urethral Gonorrhœal Warts.*

THE patient was a young man who, some three years ago, acquired a gonorrhœa which, under treatment, subsided, so far at least as the existence of a purulent discharge was concerned. A moderate gleet, however, remained, and soon he began to observe some narrowing of the stream of urine as this was expelled in the act of micturition; at times, also, the urine contained blood. For these symptoms he was treated in various ways, and though he received temporary relief, there was always sooner or later a recurrence of the urethral discharge, and of the evidences of obstruction to the outflow of urine. When first seen by Mr. Jacobson, some nine months ago, there could be seen presenting at the meatus some sessile warts with a cox-comb surface; and, on removing these, it was evident that others were present along the course of the urethra. For the purpose of getting rid of them Mr. Jacobson had passed a silver catheter with several eyes, turning it about in various directions, and in this way, the growths becoming entangled in the "eyes" of the catheter, large numbers had been removed on several different occasions. In time the patient was taught to pass the catheter himself, or rather to introduce it as far as the constrictor urethræ muscle, and he still continues to do this at frequent intervals, thus clearing out the warts as they recur. The other features of the treatment included the use of bougies containing zinc sulphate and zinc chloride, and the mixed sulphate injection.¹

Mr. Jacobson remarked on the rarity with which warts are found, as here, along a considerable part of the urethra. They are, of course, frequent on, and just behind, the glans penis, and

¹ The following is the formula of the mixed sulphate injection (Berkeley Hill):—

Alum	} of each 10 grs.
Sulphate of zinc	
„ „ copper	
„ „ iron	
Distilled water to 8 oz.	

The injection to be diluted with, at first, three times its bulk of water, and the strength gradually increased.

they are not very uncommon in the fossa navicularis. But it is quite exceptional to find them extending from this backwards towards the deeper part of the urethra. The case further illustrated the difficulty of meeting the situation created by the tendency of these growths to recur again and again. That difficulty is all the more serious when the patient desires to marry, for, apart from the fact that the discharge attending such papillary growths may continue for long to contain gonococci, it is certain that in some circumstances warts are themselves directly contagious. The practitioner should, therefore, be extremely careful in accepting responsibility for permitting the patient to marry. It may be mentioned that in the case under discussion there was some evidence of a tendency to papillomatosis, at least there was the fact that the patient had three warts on his right hand.

Two Cases of Abdominal Pain of Uncertain Origin.

The first patient was a well-nourished woman of 48 years. She complained of pain in the left hypochondrium, immediately below the costal border, and there was tenderness to pressure in this region. According to her own statement she had vomited blood at occasional intervals during the last fifteen years. There was also a history of a fall some five years ago, this being about ten months previous to the commencement of the pain. Such a history, followed by abdominal pain, suggests, in the first place, the possibility of injury to the kidney, and in the present case this suspicion appeared to be strengthened by the fact that there was undue mobility of the kidney on the left side. On the right side it is not by any means uncommon in women to find the kidney movable, and this condition is often associated with signs of gastric disturbance. But mobility of the left kidney, and especially when this occurs apart from a movable right kidney, is extremely rare, and hence when associated with a history of a fall, it is reasonable to suspect that violence is responsible for the mobility. A second possibility which comes into view when abdominal pain follows a history of injury, is damage to the fibres of the psoas muscle. This muscle is of very delicate texture, and is provided with a relatively small amount of supporting connective tissue framework. It is thus

readily damaged. This fact affords an explanation of the occurrence of psoas abscess apart from vertebral disease. The muscle becomes lacerated, and the damaged area becomes infected from the intestine, thus leading to the formation of an abscess. A third suggestion is the existence of a small sub-peritoneal hernia. Even the protrusion of a small mass of sub-peritoneal fat, as, for example, at the linea alba, between the recti muscles, may give rise to repeated attacks of vomiting and other abdominal symptoms, the explanation of which may perhaps only appear after an exploratory incision. Again, the history of hæmatemesis and of attacks of gastric pain must necessarily suggest the possible existence of peri-gastric adhesions. Such adhesions are often found in the neighbourhood of the pylorus. And there may be constriction of the pyloric orifice without external adhesions, and even without any change capable of being appreciated when the abdomen is opened and the stomach handled by the surgeon. In the present patient the restriction of the pain to the left hypochondrium, and the absence of signs of dilatation of the stomach, justify the exclusion of a pyloric lesion from the diagnosis. After discussing the several possible explanations of the symptoms, Mr. Jacobson advised that the patient should, for a couple of months, wear an abdominal bandage properly secured over the shoulders and round the groins, with a view to fix the left kidney. Should this fail to give relief an exploratory incision should be recommended. Bearing in mind that this might mean an operation on the stomach, Mr. Jacobson commented on the danger of unduly postponing surgical measures in the treatment of cases of this type. To keep a patient for a considerable time on a restricted liquid diet, and to accompany this by repeated lavage of the stomach, is to establish both local and general conditions unfavourable to operative success.

In the second patient, a man of 25 years, the pain at first sight seemed to carry a strong suggestion of renal calculus. It was referred to the right loin immediately outside the erector spinæ muscle and over the eleventh rib. There was also some pain in the front of the abdomen, and with this there was, in addition, some aching in the right testicle, towards which a shooting pain at times extended from the abdomen. A more critical analysis revealed the fact that the pain in the loin could not be very definitely localised

—it was said, for example, to pass into the right shoulder—and the point marked as painful in the front of the abdomen was not in the situation of the pain due to a renal calculus, namely, at a spot situated two inches above a line running horizontally through the umbilicus. Firm percussion over the renal region in each loin produced only very moderate complaint on either side, and not the definite tenderness associated with renal calculus. At no time had blood been observed in the urine, and there was no abnormal frequency of micturition. Discussing the diagnosis, Mr. Jacobson said that though renal calculus could not be absolutely excluded, more especially in view of the pain in the testicle (which may be the only sign of renal calculus), he was disposed to consider it improbable. The patient gave a history of a fall from his bicycle some six months ago, and Mr. Jacobson suggested that as a consequence of this there might be a small clot of blood either in the pelvis or substance of the kidney. He related in support of this suggestion the case of a man who, after being trampled on by a colt, suffered attacks of agonising pain in his right renal region, and in whom an exploratory operation discovered a firm nodule of blood-clot in the kidney substance. In the present patient the symptoms were not sufficiently urgent to justify operation, but it would be well to advise the patient to adopt measures calculated to keep the urine freely diluted and free from any crystalline deposit. The formation of a calculus demands the presence both of a crystalloid element (*e.g.*, uric acid, calcium oxalate, etc.) and a colloid element, as mucus or blood. Upon the supposition that the patient has a blood-clot in his kidney, one of these factors is already supplied. Hence it will be well to avoid the provision of the other. As an alternative diagnosis to that above suggested, it may be surmised that the patient, when he fell from his bicycle, injured his right latissimus dorsi, or the periosteum of his lower ribs, and that the pain is a consequence of scar tissue formed in the substance of one or other of these structures.

DISEASES OF THE EYE.

BY H. WORK DODD, F.R.C.S.

*Friday, February 28th, 1902.**A Case of Tobacco Amblyopia.*

THIS patient, a man of middle age, was suffering from the usual visual symptoms arising from the over-use of tobacco. He complained that his sight was gradually failing, and on submitting him to the test types the vision in each eye was found to be less than $\frac{6}{60}$. The ophthalmoscope revealed no explanation of this defect; the refractive media were clear, and each fundus was free from appreciable organic change. The only criticism which could be passed was that the temporal portion of each optic disc was somewhat pale. It is known that tobacco—and the same is true of some other toxic agents—has a specially prejudicial action upon the bundle of fibres distributed in the macular region; and as these are collected into an area in the temporal part of the disc, this region, in cases of tobacco poisoning, may appear unduly pale. A gradual failure of vision affecting both eyes and unaccompanied by distinct ophthalmoscopic changes is sufficient in itself to establish a presumptive diagnosis of toxic amblyopia; and the most frequent poison is tobacco, generally, but not invariably, in combination with alcohol. Against this diagnosis may be set the possibility of primary optic atrophy. This latter condition, however, is marked by pallor affecting the whole of the disc, and attaining a degree and character readily appreciated by anyone accustomed to ophthalmoscopic examination, and never seen in tobacco amblyopia. Further, the visual fields in optic atrophy are quite different from those in toxic amblyopia. In atrophy the peripheral part of the field suffers—that is, there is contraction of the limits of the field. In toxic amblyopia, on the other hand, it is, as already explained, the nerve fibres of the macular region which suffer; and hence, whilst the visual field has a normal peripheral extension, there will be found an area of defective vision at or near its centre. In advanced cases this defect may mean a central blind spot (absolute central scotoma), whilst in earlier cases there may be merely central failure for colour, more particularly for red and green.

This last-named feature is of great importance in the diagnosis. The failure of the sense for red sometimes leads the patient to say that his friends look paler than they used to do, and it is frequent to find that he fails to distinguish gold from silver coins, and so is apt to give away a half-sovereign in mistake for a sixpence. Another suggestive statement in the patient's story is that he sees better in the dusk than during the daytime or in the presence of a bright light. The diagnosis therefore rests upon the following facts:—(1) Gradual failure of sight affecting both eyes; (2) vision better with a dim than a bright light; (3) confusion of gold with silver coins; (4) no obvious ophthalmoscopic changes other than pallor of outer part of disc; (5) visual field not contracted, but having a central scotoma, either absolute, or for red and green only. When this combination of events occurs in a middle-aged man who is addicted to the use of tobacco there can be no doubt as to the nature of the case. The amount of tobacco needed to cause amblyopia varies with the individual, but as a rule it is found that the patient is using about half an ounce of "shag" daily.

The prognosis in early cases is good, provided the patient will abstain from tobacco in every shape and form. This is a *sine qua non*, as a very small amount of the poison may be quite sufficient to keep up a toxic neuritis when this is once established. Iodide of potassium and nux vomica are often included in the scheme of treatment. In all cases it is necessary to warn the patient that, at the best, several weeks will elapse before definite evidences of improvement will be appreciable. With a distinct absolute scotoma present, prognosis must be guarded.

Bi-lateral Paralysis of Ocular Muscles.

This case continues, and in one sense extends, the series of examples of ocular paralysis which have been presented at our clinics. In noting a case sent for consultation on January 17, 1902,¹ we drew attention to the fact that in the instance then under discussion we had a departure from previous cases in two directions. First, the paralysis was bi-lateral; and secondly, the affected nerve was the sixth, not the third. In Mr. Work Dodd's patient the

¹ See POLYCLINIC, February, 1902 p. 89.

third and fourth nerves were affected on the right side, and the sixth nerve on the left. There was complete right ptosis, and the right eyeball was carried to the outer canthus and could not be moved from that position. On the left side the eye was turned inwards, but could be moved in all directions except outwards. Thus, on the right side all the muscles of the eyeball were paralysed except the external rectus, and on the left all were vigorous except the external rectus. Such a distribution of the paralysis, arguing as it does the existence of more than one lesion, favours the diagnosis of syphilis. The presence of the Argyll-Robertson pupil, and the absence of the knee-jerks, lend strong support to the suspicion that the ocular paralyses here are merely early events in the evolution of the symptoms of tabes dorsalis.

Other cases included (1) two examples of tumour (sarcoma) of the eyeball; (2) injury to the lens; and (3) a patient with optic atrophy and diabetes insipidus. The last case is fully recorded in St. Bartholomew's Hospital Reports, vol. xxxvi. The combination is an extremely rare one. On the other hand, optic atrophy, or at least a toxic amblyopia, is not infrequent in diabetes mellitus.¹

BY E. TREACHER COLLINS, F.R.C.S.

Friday, March 21, 1902.

Tubercle affecting the Ocular Conjunctiva.

GEORGE P., aged 67 years, came to the hospital on February 27, 1902, complaining of inflammation of his left eye, which he had noticed for about six or seven weeks.

The ocular conjunctiva was somewhat injected, and upwards and inwards, a short distance from the corneal margin, was a raised nodulated pinkish-grey patch, about an inch in length and half an inch in breadth.

No specific history could be elicited, and he had had no injury to the eye. When 12 years old he had white swelling of the right

¹ See POLYCLINIC, October, 1901, vol. v., p. 179.

knee. Two years ago his right leg was amputated through the thigh after an accident.

As the nature of the new growth, from its clinical characters, was very difficult to determine, a small piece was cut out for microscopical examination. A section was shown which at once cleared up the diagnosis, as it presented the typical histological appearances of tubercle. Sufficient of the specimen had not been left for examination for bacilli.

Before the nature of the growth had been determined, the patient had been treated with iodide of potassium. It was now proposed to cut out the whole of the affected portion of the conjunctiva.

Rupture of the Sclerotic from an Injury with a Cow's Horn.

Thomas C., aged 45 years, had sixteen days ago received an injury to his right eye with a cow's horn. He was seen the following day. The conjunctiva was swollen and oedematous, and there was much subconjunctival hæmorrhage. The line of a rupture in the sclerotic could be seen upwards and outwards, 3 mm. distant from the corneal margin, and concentric with it. The conjunctiva appeared to be intact over it.

As a rupture of the sclerotic, from a sudden increase in the tension of the eye due to external pressure, always occurs in the opposite position to that in which the blow is inflicted, in this case the cow's horn must have struck the lower and inner part of the globe. Ruptures of the sclerotic are most frequently met with upwards, or upwards and inwards; the eye being, to a certain extent, protected on the inner side by the nose, and above by the brow. The rupture extends first into the extreme periphery of the anterior chamber, the vitreous chamber only being opened up if the suspensory ligament is torn through.

When first seen there was so much blood in the anterior chamber of this man's eye that it could not be determined if there was any displacement of parts. Some transverse streaks could be seen across the upper part of the cornea, evidently due to breaking of Descemet's membrane.

Vision = hand movements, and the tension was — 2. Now, to a

great extent, the blood has become absorbed. The line of rupture can be more distinctly made out as a grey coloured line. The iris upwards and outwards, in the region of the rupture, has completely disappeared. It looks just as though an iridectomy had been performed in that direction. It must have become puckered up into the gap formed in the sclerotic. There is still a blood-stained membrane filling the pupil, so that only a dull red reflex can be obtained from the fundus. Vision = fingers at 4 ft. Tension normal.

As there is a prospect of the man ultimately obtaining useful vision with the eye, and as no actual perforation has occurred, the conjunctiva having always remained intact—it is proposed to retain the eye, but a careful watch will be kept of the patient for some time, for fear of sympathetic trouble.

Patient with congenitally defective movements of one eye which made it closely simulate an artificial eye.

The appearances of this patient's left eye, a woman aged 30, so closely resembled an artificial one that many excellent observers, when they first looked at her, had been taken in by it. People who have met her have frequently asked her if she has not a glass eye. Those attending the consultation were asked to form an opinion of the case, without asking any questions of the patient, and it was evident that many present formed a wrong diagnosis.

The eye had been defective as long as she could remember. Eleven years ago it was operated on because it turned in. There was partial ptosis of the left upper lid; and limited movement of the eye upwards and outwards. On looking inwards there was some rotation of the eye downwards. The left eye was slightly less prominent than the right, *i.e.*—there was slight enophthalmos. There was extreme sinking in of the left caruncle, and some retraction of the inner part of the lower lid on that side. These two last symptoms probably resulted from the operation which had been done to correct the convergence, whereas the other defects were probably congenital, the result of faulty development or insertion of the muscles. The vision of the left eye was only equal to perception of light; that of the right eye was normal. The optic nerve on the left side was pale and apparently small.

Results of a Plastic Operation for Ectropion.

This man had been shown at a previous consultation;¹ he had ectropion of both lower lids, the result of cicatrisation following lupus. The left side had been operated on when he was previously shown.

On December 5, 1901, a piece of the whole thickness of the skin was removed from the right upper arm and transplanted to a raw surface beneath the right lower lid, after its margin had been liberated and united by sutures to the upper lid.

The flap was held in position by sutures passed over it, but not through it. Iodoform with a dry dressing was applied, and kept on for ten days without removal. The whole of the flap had taken, and the position of the lid was very much improved. There still, however, was some slight eversion at the outer angle. The transplanted piece of skin showed a number of black hairs growing from it.

DISEASES OF THE NOSE AND EAR.

BY RICHARD LAKE, F.R.C.S.

Friday, March 14, 1902.

Lupus of the Nose.

THIS patient I had the privilege of showing here nineteen months ago. She was then under treatment for lupus of the exterior of the nose, the mucosa being at that time free. The whole of the skin of the cartilaginous portion of the nose was involved. For treatment the nose was pickled in a 2 per cent. formalin solution for ten days, and the dry necrosed tissue scraped away, and skin grafts applied. This treatment has, as you see, been quite efficient, but a short time since lupus broke out inside the vestibule, and we are now treating that with the paint recommended for laryngeal phthisis, viz., R formalin 7 per cent., acid lactic 50 per cent., glycerin et aquæ, partes equales ad 100.

¹ See POLYCLINIC, December, 1901, p. 304.

Bi-lateral Mastoid Operation.

This patient was an extremely stupid girl, in fact seemed mentally deficient, before she had a double mastoidectomy for chronic otitis media suppurativa. The right side is quite cured. It was done some six months ago, and lined with one large skin graft. The other was only operated on five weeks ago, and is healing rapidly, and I am leaving it ungrafted to see the difference between the grafted and ungrafted mastoid operation.

I wish to draw your attention to the fact that on the left side there is more room in the lower and innermost part of the operation wound. This is on account of the bone being cut away more extensively over the facial nerve in its descending part.

Case of Atrophic Rhinitis.

This is a case of atrophic rhinitis in which the inferior turbinal has been replaced or restored in part by the submucous injection of paraffin wax. I brought this treatment forward recently, and this is the first case cured. I warn you, however, that "one swallow does not make a summer."

Case of Vertigo.

A case of vertigo, with staggering, after the radical mastoid operation in a girl aged 10. There was some reason to suspect intracranial mischief, viz., vertigo and staggering gait, but beyond a feeble lateral nystagmus all the other symptoms were negative. I propose only to watch the case.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. HUTCHINSON.

Thursday, April 3.

Sycosis-Keloid of the Nape.—Results of Cauterisation Treatment.

IN this case, a man aged 30, from Dr. Carmichael of Barrow-in-Furness, whose portrait had been taken in August last, attended, in order that we might compare his present state with that shown in

the portrait. In the interval he had had the actual cautery used freely eleven times. Dr. Carmichael reported that at first there had been a great tendency to rapid reproduction, and this it was which had necessitated the frequent recurrence to the cautery. The result had, however, in the end been good, and a florid scar with but little thickening replaces the thick bossy mass represented in the portrait.

A number of drawings from similar cases were shown, and I made some remarks as to the nature of the disease. It begins by indolent papules involving the roots of hairs and their appendages on the nape. These constitute the sycosis stage. They itch and are scratched, and then follows a fibroid hypertrophy of the true skin, which squeezes the hairs into tufts like those of a brush. A smooth mass of very dense induration results, which may extend, as in the present instance, right across the nape. This is the keloid stage. Even in this stage if tufts of hairs be pulled out little collections of pus may be opened, proving that there is still inflammation about the hair follicles. In the present case, in addition to the large keloid mass, there were still many sycosis papules scattered on the adjacent skin. Finally the hairs fall out, and at a yet later stage the skin may be restored to a condition of perfect integrity, minus the hairs. If the disease were exactly the same as a keloid of scar, cauterisation treatment would be inappropriate, for the condition would be certain to return. The present case showed that even in this form there was a great tendency to relapse. In others, however, very good results had been obtained.

Leprosy without Anæsthesia. Benefit from an attack of Measles.

A boy of 13 whom we have often had before us on previous occasions, attended in order to show that great benefit to the thickening of the skin of his face had resulted from a sharp attack of measles. It was three months since the attack, and his face was very much smoother than it was six months ago when we last saw him. It was a case in which the face alone showed the tuberoso condition. On the trunk there were large scorch-patches without the least thickening; and the upper extremities, although everywhere involved in a dusky dermatitis with slight solid œdema, showed no traces of nodules. They were covered on their backs with

papules like those of lichen scrofulosorum, and the same were present in large groups over the loins and hips. On the forearms there were a few patches which were becoming white, and into one of these a needle might be thrust without causing pain, although the touch of a finger could be felt. This, however, was the only aberration of sensation which we could detect on any part, although a careful examination, with the eyes blindfolded, was made. The hands could scarcely be said to be swollen, and excepting that they looked a little dusky, showed nothing particular. Their circulation was, however, very easily influenced by exposure to cold, when they became livid. The ulnar nerves in both upper arms were distinctly enlarged and somewhat tender, but no loss of sensation could be proved in the skin supplied by them, and there was no paralysis. The boy is now in the third or fourth year of his disease and was born in India. I remarked upon the rarity of such extensive changes in leprosy without more extensive diminution of sensation. No doubt it would come at a later period. I also asked attention to the great difference in the conditions of leprosy in relation with the region affected. On the trunk, kept warm by the clothes, only maculæ without thickening, on the upper limbs very slight general œdema, on the face, exposed to the cold, great disfigurement from temporary induration of eyebrows, nose, forehead, and cheeks. Many observers had noticed improvement in tubercle leprosy under the influence of an exanthem. In this instance the boy's nurse told us that immediately after the measles it would scarcely have been noticed that his face ailed anything. It soon, however, began to relapse.

Chronic Sclerosis of the Tongue, resulting in Cancer.

The subject of this case was a florid, healthy-looking man, who had suffered from syphilis twenty years ago, and had smoked ever since. For long he had had his tongue covered all over its surface with what looked and felt like white enamel—"the white-paint-tongue." Eighteen months ago a small sore formed on the right of middle line; eight or ten weeks ago this sore became painful; and now he had an ulcer as big as a shilling, clean on its surface, deep in its middle, and with edges and base exceedingly hard. There could not be the slightest doubt about its nature or about the measure of treatment

necessary. I advised immediate removal of the whole tongue and the right submaxillary gland, together with all lymphatics near to it. There was no positive enlargement of these glands, but a little suspicious thickening, and with a cancerous sore so far advanced, it was, I remarked, quite certain that they were already infected.

I remarked upon the extreme importance of early diagnosis in these cases, and said that skill in it could only be obtained by educating the eye and the finger. It is part of the object of the Polyclinic to afford frequent opportunities for such education.

As regards the relation of the disease to the foregoing syphilis, I remarked that it was remote and indirect. It was epithelioma supervening on sclerosis, not on gumma, and the growth had been from the surface downwards. In truth the man's smoking had had more to say to the sclerosis than had his syphilis. Not even in the earliest stage of such an ulcer could the use of anti-syphilitic drugs be of the slightest use.

Tumours in the Abdominal Wall near the Navel.

The patient in this case was a tall gaunt man of 60, formerly a soldier. For some months he had complained of difficulty in swallowing and had latterly been unable to take solids. He said that he had appetite, but that he could not get food down, and he located the place of stoppage as behind the lower part of the sternum. He never brought food back again, and never vomited. He had been to St. Mary's Hospital, where a bougie was passed without difficulty. Latterly there had appeared in the abdominal wall, just above the navel, three tumours as large as half-walnuts. Two were quite movable, but one fixed. They did not involve the navel itself, but it was doubtful whether the structure at its apex were not indurated. No enlargement of the liver nor any tumour in the abdomen could be detected.

My diagnosis was a new growth deeply placed in the upper part of the abdomen pressing upon the stomach. As regards the tumours they must be regarded as resulting from infection, which had possibly travelled along the lymphatics in the round ligament of the liver. This structure, I remarked, ought always to be suspected when growths appeared at the navel. Primary disease of this structure is very rare, but secondary ones not uncommon.

Blue Stains on the Feet in a Young Girl.

A girl of 14 presented her two feet, the toes of which showed a number of dull, deep blue stains. They were in streaks and irregular patches, and occurred on the toes, between them, and on their plantar surfaces. They were arranged with almost exact symmetry, and upon the ball and sides of the great toes took precisely the region of distribution of the long saphena nerve. The skin upon which they occurred was sound, with the exception that here and there was a slightly congested border. At first sight I felt no doubt that it was a case of malingering, and expected the blue to wash off. I was told, however, that it could not be removed, and we confirmed this by trial. The skin was deeply stained, perfectly smooth, and not in the least influenced by wasting or rubbing. Nor did the colour disappear on pressure. We discussed Raynaud's phenomena, chromidrosis, etc., and finally decided to have experiments performed with aniline dyes, etc., to see if similar conditions could be produced. The general impression was that such abrupt patches and streaks so entirely without association with other peculiarities could only be factitious. In confirmation of this was the statement that two years ago the girl had similar patches, and that at that time a sister of hers had some also. The girl was liable to chilblains, and was troubled by profuse perspiration of the feet. She had never, however, been the subject of Raynaud's phenomena.

REVIEWS AND NOTICES OF BOOKS.

LECTURES ON CHEMICAL PATHOLOGY. By C. A. Herter, M.D.
Smith, Elder & Co., London, 1902.

WE very cordially commend this volume of lectures to our readers' attention. Whilst it deals, as its title implies, with one of the most complex and abstruse aspects of pathological science, it is singularly free from dry-as-dust qualities, and it is most successful in associating the facts and doctrines of chemical pathology with the demands of practical medicine. This is indeed its leading motive. The author, moreover, not only has the technical equip-

ment necessary for his task, but he uses a literary style which renders the perusal of his pages as pleasant as it is profitable.

HERNIA, ITS ETIOLOGY, SYMPTOMS AND TREATMENT. By W. McAdam Eccles, M.S., F.R.C.S. Second Edition. Baillière, Tindall & Cox, London, 1902.

MR. MCADAM ECCLES is to be congratulated on the recognition extended to his monograph. The care and detail with which he discusses the various aspects of his subject are claims to success, and we are glad to find that they are meeting with the attention they merit. The chapters which deal with the application and use of trusses, and the excellent photographs which illustrate these, must be of considerable practical value to those engaged in general practice.

ILLUSTRATED MEDICAL DICTIONARY. By W. A. Newman Dorland, A.M., M.D. W. B. Saunders & Company, London and Philadelphia, 1900.

THIS volume is the outcome of an attempt to find a *via media* between the encyclopædic and bulky lexicon on the one hand, and the bald abridged list of definitions on the other. As the first test of a dictionary is the utilitarian one, we have subjected this to a number of technical demands, and it is only just to say that it has passed through the trial with every credit to its author. The publisher and printer are also to be awarded a due share of recognition, for clear type and efficient binding are specially welcome in a book used for purposes of rapid reference. There are, as is to be expected considering its transatlantic origin, peculiarities of spelling to which our old-fashioned orthographical taste does not readily accommodate itself, but we can hardly urge this objection on practical grounds. We venture also to think that the term "illustrated" is not happily chosen. To us, at least, it implies a much more extensive pictorial scheme than the present dictionary attempts. Some of the larger plates are in every way successful, but there are others which hardly rise above the level of the popular handbook on ambulance work. But so far as the main purpose of a dictionary is concerned, Dr. Dorland's work both in substance and in form is a decided success.

A TEXT BOOK OF HISTOLOGY, INCLUDING MICROSCOPIC TECHNIC.

By A. A. Böhm, M.D., and M. von Davidoff, M.D. Edited by G. Carl Huber, M.D. With 357 illustrations, pp. 500. Price 15s. Saunders & Co., 161, Strand.

THIS is a translation of a German text book, which has reached a second edition. It has, however, been edited by an American professor, who informs us that he has made some changes in the arrangement of subjects, and greatly expanded certain sections. Its authors are two physicians engaged in the anatomical laboratory of Munich, and it is apparently based to some extent on the lectures of Professor von Kupffer. Its editor is Carl Huber of the Michigan University, and finally it is translated by Dr. Cushing. We have nothing but praise for the authors, the editor and the translator. The work, originally good, has been improved as it has passed through the editor's hands, and many new illustrations have been introduced. The translation is for the most part into good English, and it is only here and there that we encounter obscurities. The book is a companion to the laboratory as well as a text book of histology, and it is sure to become popular in England with both teachers and students.

CATALOGUE-COMPANION TO THE MUSEUM.

(Continued from page 265 vol. v.)

SATELLITES are always closely adjacent to the parent patch and never at great distances. The locally infective stage of lupus vulgaris usually lasts many years, and may extend over a whole life, but its manifestations are always restricted to the localities first attacked. Certain parts of the surface are more prone to be attacked by lupus vulgaris than others. It is prone to begin on the tip of the nose or on the middle of the cheeks, and is often seen on the hands and feet, whilst the parts well protected by clothing, although by no means exempt, are less frequently its seats. In some cases the patch is a single one and remains so through the whole course, but in a majority more than one are present, and in a few the number

may be indefinite. However numerous the patches of lupus vulgaris may be they are never, excepting by accident, arranged with anything approaching to accurate symmetry, but are scattered irregularly. Whenever the patches of lupus vulgaris are numerous there is almost always the history that they were all developed in the early stage, that is, within a few months of the first appearance of the disease. In like manner if there be a tendency to spontaneous cure it is almost always shown in the early stages. After once the patches have become chronic, they are remarkably persistent, although they may spread only very slowly. The lobules of the ears are apt to be affected in lupus vulgaris and to become a thick mass of firm, jelly-like material. Lupus vulgaris is invariably made worse, that is, more inflamed, by exposure to cold, and its conditions as regards ulceration vary with the part most affected, this being most prone to occur on the nose, hands and feet, parts in which the circulation is at a disadvantage. The form of dermatitis which characterises lupus vulgaris is essentially destructive, and a scar more or less conspicuous is its invariable result.

In lupus vulgaris the mucous membranes of the orifices may be affected, and that either primarily or secondarily.

It has been necessary to give this lengthy description of the features of that form of lupus to which the adjective vulgaris is applied in order that we may be in a position to classify cases with some approach to accuracy. It would not be difficult to construct a short definition which adequately distinguish it from other forms of skin disease, such as psoriasis, eczema, and the like. It is, however, quite impossible to distinguish it from other types of lupus without going into great detail, and even when this is done our criteria will in many instances fail. For a true comprehension of the facts it is absolutely necessary to rid the mind of the idea that the difficult clinical types of the disease with which we have to deal in any degree approach the rank of different species. They are all modifications of the same process, and result from the varied combination and interfusion of the same elements of causation. From this it results that we ought not to expect to establish abrupt lines of demarcation, and that we ought to count upon finding many cases which are connecting links, and which it is impossible to classify.

SERIES "A." LUPUS VULGARIS.

No. 1 (*Willis's Atlas*).—A portrait, taken from Willis's Atlas, showing the face of a girl affected with lupus exedens. The end of the nose with the septum, and the alæ and columna, have been destroyed. Patches of congestion extend over both cheeks with still persisting ulceration at two or three points. The upper lip is much swollen and in a condition of solid œdema ("lupus hypertrophicus").

No. 2 (*Original. J. H.*).—A single, almost round patch of non-ulcerated lupus in the middle of the cheek of a young man. It had been present for some years, and was steadily advancing at its edge, but without any secondary formations and without any tendency to ulcerate. A cicatrix is seen in its middle. Its edge was of considerable thickness and showed well the semi-transparent reddish jelly which characterises lupus growth. The patient was under Mr. Hutchinson's care in 1868, when the whole was destroyed by a free use of the actual cautery.

In the same frame with this is the following, showing very similar conditions.

No. 3 (*Original. J. H.*).—A portrait showing a single patch of lupus on the cheek. The patch had been present for many years, and was slowly extending at its edge, but without producing any satellites or growths at more distant parts. There is a scar in the middle of the patch, but the margins are thick and elevated. They show well the semi-transparent brownish infiltration, which has been described as the "apple-jelly deposit," characteristic of lupus vulgaris. The patient was a middle-aged lady in good health and with no appreciable tendency to scrofula. She subsequently had a growth of rodent cancer on the upper part of the cheek at a considerable distance from the patch of lupus. This was destroyed by the actual cautery, and the scar remained sound. Fifteen years later this patient again came under care with a small growth of epithelial cancer in the middle of the lupus scar. This was destroyed by very free use of the actual cautery, and at present (1901) the scar is sound. This patient has been under Mr. Hutchinson's observation for twenty years and has several times attended at the Polyclinic. She has declined radical treatment for the original lupus and it has slowly advanced. There is another portrait illustrating recent conditions (see Lupus-Cancer series).

No. 4 (*Hebra's Atlas*.)—A portrait from Hebra's Atlas (Tafel V.), named by him "Lupus Serpiginosus Hypertrophicus." The disease involves the whole of the face and a large part of the neck. The characters of the non-ulcerating form of lupus are well seen in the latter region, where there is a spreading edge, consisting of small tubercles, which leaves behind it a healthy scar. Many little satellite tubercles are seen. On the face, and especially in connection with the lips and adjacent parts, there is much œdematous hypertrophy, attended with superficial ulcerations. The nose has been in part destroyed. The disease involves the eyelids and ears, and has partly destroyed the former on the right side. The portrait is that of a young man.

No. 5 (*Cazenave's Atlas*.)—A portrait from Cazenave's Atlas showing "Lupus Tuberculeux." The portrait is that of a young woman in whom lupus-ulceration has spread over the front of the neck, and invaded, almost symmetrically, the chin and cheeks. The edge is everywhere covered with a pus-scab. The scar is florid and of a dusky purple. The case is one of the more superficial forms of common lupus. Very probably there were other patches on the limbs or trunk.

No. 6 (*Original. J. H.*)—Portrait of Mrs. Elesmore, aged 75, inmate of Kensington Infirmary. This old woman had become the subject of lupus, which had extended from her nose, in bat's wings on both cheeks; it was ulcerated and crusted. Although symmetrical it should be regarded as lupus vulgaris. The portrait is especially valuable as illustrating lupus beginning in old age. It had been present only three or four years at the time the portrait was taken. (By Swainson.)

No. 7 (*Hebra's Atlas*.)—A portrait from Hebra's Atlas, showing large patches of lupus vulgaris covering the cheeks, and passing under the chin. The nose is not affected. The patches are in part superficially ulcerated, and the patient is apparently a middle-aged woman.

No. 8 (*Cazenave's Atlas*.)—A portrait from Cazenave's Atlas, under the name "Lupus Ulcereux." The end of the nose has been extensively destroyed, and there is a large ulcerated surface involving the whole upper lip, covered with bossy masses of firm granulations.

The erythema which has spread on the cheeks is almost symmetrical. The portrait is apparently that of a young man.

No. 9 (*Original. J. H.*)—In these portraits, from the same patient, patches of lupus vulgaris of a very superficial kind are represented upon the arm and ear of a young woman. The apple-jelly condition is not characteristically seen anywhere. The patch on the arm shows indolent tubercles on some parts of its edge, and a scar in its centre. On the ear the lobule is affected, and on the skin of the neck, immediately beneath it, there are satellite spots so superficial that they might rank as eczema-lupus.

No. 10 (*Original. J. H.*)—Two portraits of the ear of Miss L. J. They show a condition of lupus which closely simulates eczema, and might easily be mistaken for it. In one the patches are shown behind the ear, and in the other they occupy the whole of the concha, spreading upon the helix. It will be seen that in both situations a condition of scar is left in the part where healing has taken place. The conditions had been slowly advancing for several years, and were coincident with similar disease on the nose. The patient was a lady of about 35. The portraits were taken in June of 1884.

No. 11 (*Hebra's Atlas.*)—The tenth plate from Hebra's Atlas, described by him as "Lupus Serpiginosus Hypertrophicus." It appears to be an example of lupus spreading very extensively, and leaving, as usual, a scar where its processes have ended. There does not appear to be much reason for styling it "hypertrophic." The edge of the patch is everywhere covered with pus-scab, and there are everywhere superficial ulcerations. Only by the history of the case would it be possible to diagnose such a condition from syphilitic lupus.

No. 12 (*Wilson's Atlas.*)—A portrait from Wilson's Atlas, published under the title of "Lupus Non-exedens." It shows the face of a woman in whom the cheeks, nose and upper lips are involved in a superficial form of lupus. The margins of the patches are attended with broad papules or tubercles, which are described as presenting their characteristic dull red colour and jelly-like appearance. The patient was 37 years of age, and the disease had commenced at the age of four. She had had much treatment, and

it is stated that caustics had caused the disease to spread. She recovered under a two years' treatment with ten minim doses of Donovan's solution.

No. 13 (*Cazenave's Atlas*.)—A portrait from Cazenave's Atlas, published under the name of "Lupus Hypertrophique." The tip and alæ of the nose have been destroyed by ulceration, and the orifices of the nostrils are much contracted. There is an almost symmetrical condition of deep purple erythema affecting the upper lip, cheeks, and chin. It is attended by a good deal of solid œdema, on account of the presence of which the term "hypertrophique" was no doubt given.

No. 14 (*Original. J. H.*)—The portrait of a young lady who died of pulmonary phthisis about a year after it was taken. She was of a somewhat delicate family, and one of her sisters subsequently suffered from lupus of the septum nasi. There was no syphilis in the case. The portrait was taken in order to show the very extensive ravages which occasionally attend lupus when it attacks the lips. It will be seen that the whole of the parts around the mouth have been destroyed, together with the entire upper lip and a great part of the nose. The ulcer was usually crusted over with a thick scab, and readily bled when the latter was removed. The treatment had, in the earlier part of the case, unfortunately been neglected, on account of the patient's unwillingness to submit to the pain which it caused. Had she survived, it is probable that the final condition, after cicatrisation, would have resembled that shown in the woodcut given at page 376, "Archives," vol. iv. The case is of interest on account of the association of lupus with pulmonary phthisis in the same individual, and with ulcer of the septum in a sister.

CORRESPONDENCE AND ANSWERS.

GRAVES' DISEASE AND RHEUMATISM.—We are indebted to Dr. H. M. Stewart (Assistant-Physician, Home for Sick Children, Dulwich), for the following illustrations of the association of Graves' Disease and Rheumatism as referred to in our last issue (p. 115):—

(1) Miss B., aged 20 years, came under my notice about a fortnight ago complaining of joint pains. The temperature was raised, and she was undoubtedly

suffering from a mild attack of acute rheumatism. There was a mitral regurgitant murmur. In addition, she had marked exophthalmos, and the thyroid gland was considerably enlarged. Both of these latter symptoms had been present some three or four years. She had had a previous attack of acute rheumatism.

(2) Henry C., aged 28 years, first had acute rheumatism in 1894, when it was noticed that his eyes were prominent and that he had a swelling in his neck. He had been losing flesh for three years. He came under my observation later in the same year, and was found to have mitral regurgitation in addition to exophthalmic goitre. He improved under treatment so that he put on 10lbs. in weight, and the exophthalmos diminished; he then developed polyuria, one day passing 130 ounces of urine, but no sugar was found. In December, 1894, he was again seen, and sugar was present in the urine; the other symptoms remained as above described. In March, 1895, he had a severe attack of influenza and became very weak. He was then passing about 2,000 grains of sugar daily. The exophthalmos was slight, and the thyroid not obviously enlarged. He again improved under treatment, and the sugar gradually diminished. Shortly afterwards I lost sight of him but believe he died the same year. [Polyuria and glycosuria have each been noted as occasional symptoms in exophthalmic goitre. Dr. George Murray, in 1897, reported a case of acromegaly, exophthalmic goitre, phthisis, and glycosuria. The patient is figured in Clifford Allbutt's "System of Medicine," vol. iv., p. 491.—C. O. H.]

* * *

SOLOMON PEDANT, M.D., is thanked for his communication. He is, of course, quite right. Juvenal certainly wrote *res angusta domi*, and we apologise for our oversight in proof-reading. Even an Editor sometimes nods. We are fortunate in having a wise schoolmaster to deal with our delinquencies.

* * *

"LOOKING back on my *Lehrjahre*, I am sorry to say that I do not think that any account of my doings as a student would tend to edification. In fact, I should distinctly warn ingenuous youth to avoid imitating my example. I worked extremely hard when it pleased me, and when it did not—which was a very frequent case—I was extremely idle (unless making caricatures of one's pastors and masters is to be called a branch of industry) or else wasted my energies in wrong directions. I read everything I could lay hands upon, including novels, and took up all sorts of pursuits to drop them again quite as speedily. No doubt it was very largely my own fault, but the only instruction from which I ever obtained the proper effect of education was that which I received from Mr. Wharton Jones, who was the lecturer on physiology at the Charing Cross School of Medicine. The extent and precision of his knowledge impressed me greatly, and the severe exactness of his method of lecturing was quite to my taste. I do not know that I have ever felt so much respect for anybody as a teacher before or since. I worked hard to obtain his approbation, and he was extremely kind and helpful to the youngster who, I am afraid, took up more of his time than he had any right to do. It was he who suggested the publication of my first scientific paper—a very little one—in the *Medical Gazette* of 1845, and most kindly corrected the literary faults which abounded in it, short as it was; for at that time, and for many years afterwards, I detested the trouble of writing, and would take no pains over it."—"Autobiography." Professor Huxley.

MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

SCHEDULE OF CLINQUES AND LECTURES

From **APRIL** to **JULY**, 1902.

Cliniques at 4 p.m.

MONDAYS. (Skin)	TUESDAYS. (Medical)	WEDNESDAYS. (Surgical)	THURSDAYS. (Surgical)	FRIDAYS. (Eye, Ear, Nose, and Throat)
			April 3 Mr. Hutchinson	April 4 Dr. Herbert Tilley
April 7 Dr. J. M. H. MacLeod	April 8 Dr. James Taylor	April 9 Mr. J. Hutchinson, Junnr.	April 10 Mr. Hutchinson	April 11 Mr. R. Lake
April 14 Dr. T. Colcott Fox	April 15 Dr. W. Ewart	April 16 Mr. Howard Marsh	April 17 Mr. Hutchinson	April 18 Mr. N. MacLehose
April 21 Dr. A. Whitfield	April 22 Dr. Harry Campbell	April 23 Mr. Jackson Clarke	April 24 Mr. Hutchinson	April 25 Dr. St. Clair Thomson
April 28 Dr. J. Galloway	April 29 Dr. Seymour Taylor	April 30 Mr. J. Berry	May 1 Mr. Hutchinson	May 2 Mr. P. R. W. De Santi
May 5 Dr. J. F. Payne	May 6 Dr. Theo. Williams	May 7 Mr. J. Hutchinson, Junnr.	May 8 Mr. Hutchinson	May 9 Mr. Marcus Gunn
May 12 Dr. A. Whitfield	May 13 Sir Wm. Broadbent	May 14 Mr. A. H. Tubby	May 15 Mr. Hutchinson	May 16 Dr. Herbert Tilley
May 19 <i>Whit Monday</i>	May 20 Dr. W. Ewart	May 21 Mr. J. Cantlie	May 22 Mr. Hutchinson	May 23 Dr. Dundas Grant
May 26 Dr. J. F. Payne	May 27 Dr. R. L. Bowles	May 28 Mr. A. H. Tubby	May 29 Mr. Hutchinson	May 30 Mr. Ernest Clarke
June 2 Dr. J. J. Pringle	June 3 Dr. James Taylor	June 4 Mr. Jackson Clarke	June 5 Mr. Hutchinson	June 6 Dr. Jobson Horne
June 9 Dr. T. Colcott Fox	June 10 Sir Wm. Broadbent	June 11 Mr. P. J. Freyer	June 12 Mr. Hutchinson	June 13 Mr. R. Lake
June 16 Dr. A. Whitfield	June 17 Dr. C. O. Hawthorne	June 18 Mr. E. W. Roughton	June 19 Mr. Hutchinson	June 20 Mr. Work Dodd
June 23 Dr. J. M. H. MacLeod	June 24 Dr. Guthrie Rankin	June 25	June 26 Coronation Day	June 27
June 30 Dr. J. F. Payne	July 1 Dr. Theo. Williams	July 2 Mr. Reg. Harrison	July 3 Mr. Hutchinson	July 4 Dr. Dundas Grant
July 7 Dr. T. Colcott Fox	July 8 Dr. Seymour Taylor	July 9 Mr. J. Berry	July 10 Mr. Hutchinson	July 11 Mr. Treacher Collins
July 14 Dr. J. Galloway	July 15 Dr. J. E. Squire	July 16 Mr. J. Cantlie	July 17 Mr. Hutchinson	July 18 Dr. St. Clair Thomson
July 21 Dr. E. Graham Little	July 22 Dr. Harry Campbell	July 23 Mr. Johnson Smith	July 24 Mr. Hutchinson	July 25 <i>College closes.</i>

Clinical Lectures at 5.15 p.m.

April 23rd.—F. W. Mott, Esq., M.D., F.R.C.P., F.R.S.
 May 7th.—Sir John Batty Tuke, M.P., M.D., F.R.C.P.
 May 21st.—J. Bland-Sutton, Esq., F.R.C.S.
 June 4th.—C. Theodore Williams, Esq., M.D., F.R.C.P.

June 18th.—Frederic Eve, Esq., F.R.C.S.
 July 2nd.—W. Hale White, Esq., M.D., F.R.C.P.
 July 16th.—Sir Anderson Critchett, M.A.,
 F.R.C.S., Ed.

Special Courses of Lectures at 5.15 p.m.

April 18th, 25th, and May 2nd.—Dr. William Hunter, "The Nature and Etiology of Pernicious Anæmia" (with lantern demonstrations).
 May 5th and 12th.—Dr. Hugh Playfair, "The Hæmorrhages of Pregnancy."
 May 9th, 23rd and 30th.—Dr. Jobson Horne, "Tuberculosis of the Ear, Nose, and Throat."

May 26th, June 2nd and 9th.—Mr. F. C. Wallis, "The Diagnosis and Treatment of Rectal Diseases."
 June 6th, 13th and 20th.—Mr. Charles Ryall, "Cancer of the Breast, and its Treatment."
 June 16th, 23rd and 30th.—Dr. Alexander Morison, "The Nature, Causes, and Treatment of Cardiac Pain."

A. E. HAYWARD PINCH, F.R.C.S., *Medical Superintendent.*

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES' COLLEGE, LONDON.

VOL. VI., No. 5.—MAY, 1902.

LEPROSY IN TRACADIE.

FROM Captain McGowan, R.N., who, in 1889-90, was personally familiar with the whole region, we have had the following facts supplied as to the district in New Brunswick in which lepers are found. He told us that he had seen many—he thought not fewer than thirty—in the leper home at Tracadie. They were all of French descent, and of the very poorest class of fishermen. They are a degraded and helpless class of servants, almost serfs, in the employ of traders by whom the fish caught is exported. Their food is almost exclusively salt fish and potatoes. The export is chiefly fresh fish packed in ice for American ports. “Why,” we asked, “do the fishermen export the fresh fish and eat the salt fish themselves?” “Well, you see, they are blocked up with ice eight months of the year, and during that period they can catch little or no fish, and their only food is then that which they have salted.”

Captain McGowan described these fishermen as living in a very miserable condition in poor huts, and as being greatly wanting in energy. They keep a few pigs, which feed on the shores of the great lagoons which border the coast, but scarcely any other animals. Our informant had seen several members of the same family affected with the disease. He believed that it was confined

to the Tracadie coast, as he had never heard of it in other parts of Canada, Newfoundland, Nova Scotia, &c.¹

The Tracadie district is the coast of a promontory in the Gulf of St. Lawrence, bounded north by Chaleur Bay and south by Miramichi. There are two short rivers known by the name of Tracadie, and two gullies on the north and the south. It is the most desolate part of the New Brunswick coast. In the interior of the country excellent crops of wheat and potatoes are grown, but near the coast little except potatoes is produced.

Leprosy has been recognised in Tracadie for several generations, and neither increases nor diminishes. It never spreads to others than the fisher families. Amongst them it may possibly be increased by commensal communication, but its chief cause is probably the excessive use of salt fish during the long winters. Believers in the hereditary transmission of leprosy may find there certain facts apparently in strong support of their creed, for it has undoubtedly prevailed in families. The explanations just suggested are, however, more probably the true ones.

In mentioning places (in our last month's Leader), in which isolation measures have notably failed to influence the prevalence of leprosy, we might have very fairly included this district. According to a paper by Mr. F. C. Welch, in the *Lancet*, December 5, 1874, the failure, up to that date, had been complete. That it is so up to the present time Captain McGowan's evidence proves. Thirty years previously—1843—as the disease appeared to be on the increase, and some of English descent were believed to have died of it, “a very stringent law was passed directing the seclusion of the lepers, and authorising any member of a local Board of Health, constituted by the Act, to commit to the lazarettos any person afflicted with the disorder. At that time there were twenty-three inmates of the hospital, thirteen males and ten females, all of whom were French Roman Catholics, belonging to families of the lowest class.” Mr. Welch quotes the above from a report by Sir A. Gordon, the Governor of the Province. He then proceeds to state that the disease was in his own time as rife as ever. “Here, then, in this

¹ In this his information is not quite accurate. Isolated cases have from time to time been observed in these parts.

small district," he writes, "the disease is endemic, in spite of the attempts of the Government, by isolation, to extirpate it. It maintains very much the same proportions of late years, despite removals of the afflicted into the hospital as early as possible and as soon as the disease is declared."

Mr. Welch proceeds to examine with much acumen the reason for this failure, and finds it chiefly in the supposition that the disease is hereditarily transmitted from generation to generation, intensified by close inter-marriages; and he concludes with the suggestion that "stamping-out," in the stockbreeder's meaning of the words, would be a benefit to humanity. Of course he does not, for a moment, advocate such a measure, but he is evidently of opinion that it would be the only effective one. It is to be hoped that it may be shown that in this he takes far too gloomy a view of the situation.

Although Mr. Welch has recorded respecting those who suffer such items as the following—"they are generally poor, their staple flesh-food is salt-fish," "so far as the coast line is concerned, it will be seen that they corroborate the localisations of the disease in Norway," and "so common is the salt herring as food among this community that the nickname of the entire French population is 'hareng,'" yet he puts aside the hypothesis that salt-fish is the cause of the disease. His only reason for doing so appears to be that, although "possibly they may be poorer than the English-speaking, yet the living, to a great extent, on salt provisions is common to both, and the Indians, in no small degree, equally use the fish so plentiful along the coast." Now, before a general statement of this kind is allowed much weight, it is needful to look a little into detail. As regards the Indians, it is probable that they eat their fish fresh and not salted, and that, in the winter months, they retire further inland and procure game. Precisely the same immunity of Indians, in comparison with fishermen, is asserted in Essequibo, and is explained in the manner suggested. As regards the English-speaking residents, it is not quite the fact that they do wholly escape, for there have occurred instances of leprosy among them, and although it is no doubt true that they eat a great deal of fish, it is probable that they are not dependent upon it to anything like the degree which the poor French fishermen are, whilst what they

do eat is probably of better quality. Moreover, the French are Roman Catholics, and keep their fasts, which neither the Indians nor the English concern themselves with. These considerations may (if verified by observation on the spot) amply suffice to explain the racial incidence of leprosy in Tracadie, whilst leaving the salt-fish hypothesis untouched.

One lesson may be learned from what occurs in Tracadie, which is of great importance. It is one which is enforced by the experience of many other places, and it is this: that the existence from year to year of a leprosy colony or "focus" is no source of contagion-danger to the general population. Here we have the French fishermen suffering from leprosy for a century—or possibly for nearly two—and yet the disease is still confined almost absolutely to them. Nor does it appear to have increased even amongst themselves. The original cause has remained in operation all the time, and about the same totum of victims, and no more, has been persistently claimed. Much the same experience is to be recorded of Iceland, and, if we mistake not, of many leprosy centres on the shores of the Baltic and the Mediterranean. In Spain, Portugal, Italy, Crete, Malta, on the coasts of the Black and Caspian Seas, little leprosy colonies have existed from time immemorial, and they still exist without showing any tendency to increase.

The facts just stated appear, we may point out, to have a very important bearing both upon our conceptions as to the cause of leprosy and the advantages of segregation for its control. A popular creed accuses the Crusades of having spread leprosy from the East over Europe. But the intercourse of nations is now far in excess of anything which attended the Crusades. Leprosy centres are abundant, and yet the disease does not spread. No new centres arise. Nay, even the lepers themselves travel about and settle where they will, and yet they infect no one. It must be clear that certain local conditions are needful for the production of the disease, and that we ought to look rather to the discovery and removal of these conditions than to anything in the disease itself, or directly associated with its victims. In the present day certain races only appear to possess the power of carrying leprosy about with them. These are the Chinese and the Malays, and perhaps, in the future, we may have to add the Japanese. But these people, when they migrate,

take with them their customs as well as their bodies. They teach the arts of fishing and of curing fish, and become food-providers and cooks. It is not necessary, therefore, to attribute a disease which follows in their wake to contagion, for it may be due to change in dietetic habits.

The advocates of compulsory segregation base their demands on two motives: the fear that the disease may spread to the general community of the district, and the desire to exterminate it from a place in which it already prevails. The first of these is the principal motive which, we believe, at present moves the authorities, and those who impel the authorities, in South Africa. The fear of contagion has developed to an absurd extent in the popular mind. A Natal farmer will fear to let his family drink of a stream which has come past a kraal in which there is a leper, and will himself not approach within a mile of such kraal. Yet—although we now hold it proven that commensal communication is possible—it is obvious that there are no grounds whatever for fears of the kind alluded to. Although plenty of foci exist in the Kaffir kraals of Natal, no instance of the disease spreading to the white population has ever occurred. As regards the hope of rooting the disease out by segregation, we have perhaps said enough to show that no success has ever been obtained where the social conditions which had produced it remained unchanged. It is, of course, indisputable that segregation may prevent a certain number of cases originating from personal communication. These are, however, probably but few in number, and the question remains an open one, whether the misery which such measures necessarily entail does not far exceed that which they can possibly prevent.

A CORRECTION.—At page 171 we inadvertently wrote—"So long ago as 1856 it was claimed that under segregation methods leprosy had diminished 50 per cent." It should have been during the eighteen years following 1856. We quoted from Hillis, who writes—"In Norway in eighteen years, from 1856 to 1873, by enforcing strict segregation the number of lepers decreased from 2,850 to 1,856, or 56 per cent." Our concern was to deny that at this time any efficient segregation was attempted, and this slight error as to date does not affect our statement.

BRONCHOCELE AND OTHER DISEASES OF THE THYROID.

AFFECTIONS of the thyroid gland have recently engaged considerable attention in our pages.¹ One field of interesting enquiry has been the topographical prevalence of bronchocele. Those who took part in the Polyclinic excursion to Guildford and its neighbourhood last September, will remember that we then received some important items of information. We were told that bronchocele was very common in the district of Pirbright; that it occurred sparingly about Guildford; and that there had recently been an epidemic of it in King Edward's School at Witley. Now as Witley is on the "Green sandstone" (under the chalk) and Pirbright on the "Bagshot sand" (above the chalk), it seemed very clear that geological formation had nothing to say in the matter. On the other hand, there appeared to be good reason to suspect the water of special wells, and the result of our inquiries was in favour of the hypothesis that the disease is induced by special organisms which may be bred quite locally and which infest wells rather than streams.

Since the interesting Clinical Excursion to which we have referred we have received from Dr. Baker (who was our host at the Witley Poor-Law Asylum) the particulars of an interesting case which supports the opinion just expressed.

A girl aged 19, a native of Devonshire, and with no known history of bronchocele in the family, having been resident at Witley two years, became the subject of full-neck. The thyroid was very considerably enlarged, and continued so in spite of the use of 5-grain doses of iodide of potassium. She left Witley and went to Yeovil, and within a few days it became smaller. She remained in Somersetshire three weeks, and at the end of the time thought her neck reduced almost to its natural dimensions. Returning to Witley and drinking the same well-water as formerly, in the course of a few days the thyroid again became enlarged. The well in question is a rather deep well, which has not been opened or cleaned out for

¹ See Vol. v., pages 161, 200, 206, 215, 217, 218, 259, 300, and 320.

many years. It supplies two cottages standing by themselves on the brow of a slope, and somewhat higher than the rest of the village. The girl in question is the only young person who drinks the water.

There appears to be some reason to believe that bronchocele is prevalent in the neighbourhood of Oxford. It would be of interest if some observers on the spot would look into the matter and record the results. Our Committee on Climates and Distribution of Disease would be very glad to receive and consider any facts which might be supplied. The statistics of the Radcliffe Infirmary on this point would be valuable.

In recording¹ a case of bronchocele in a boy of 16 in whom it had been necessary to perform tracheotomy for dyspnoea, Mr. Symonds made the statement that there was a good deal of bronchocele around Oxford. He added that it was a common affection amongst the out-patients of the Radcliffe Infirmary. An interesting feature occurred in the case referred to. The bronchocele was not large, and had even escaped the observation of the patient himself. It had, however, compressed the trachea laterally. Mr. Symonds removed one half of the thyroid gland a month after the tracheotomy had been done. After the second operation, the tube was removed and the patient remained without relapse.

It would appear that there is reason for believing that bronchocele is not common in South Africa. A letter was published in the *Times* a few weeks ago from Mr. Ewart Grogan, an observer who had travelled in the Zambesi and Lake districts, in which the statement occurred that he had never seen goitres excepting in certain villages in the Shiré valleys, where they were common. This is in a district somewhat north of what is meant by South Africa.

The writer, during a recent tour in certain parts of Cape Colony (the south) and Natal, made enquiries at hospitals and of very many local practitioners, with a uniformly negative result. Everyone said that bronchoceles were exceedingly rare and operations never required. Only one single instance came under his own observation. It was in a Kaffir girl, the subject of leprosy, in a country district not far from Ladysmith. This girl had a very symmetrical bronchocele

¹ See *Illustrated Medical News*, March 23, 1889, page 270.

of some size. It was quite loose and caused her no inconvenience. None of her relatives were similarly affected.

Hirsch¹ makes, so far as we can find, no special mention of the South African districts. Respecting the continent as a whole we have the following:—"Like the coast regions of all other parts of the world, those of the African continent, and the river basins adjoining them, are entirely free from endemic goitre and cretinism; these include Lower Egypt, the Abyssinian basin, the east and west coasts, and the littoral of Algiers. On the other hand goitre is endemic on the Abyssinian plateau, in a few localities in Sennaar, on the slopes and in the valleys of the Atlas (*e.g.*, in Kabylia), in the mountainous parts of Morocco, and to a very considerable extent in the basin of the Niger." He quotes from Quintin as the result of personal observations, the statement that "goitre is widely endemic in the valleys of the greater Soudan." It is said to have minor centres in the Azores and Madagascar. In Madeira it is very rare.

The association or otherwise of the group of symptoms known as "Graves' disease" with a pre-existing tendency to ordinary bronchocele, is a question of much clinical interest; and it may be well here to add that none of the writer's South African informants could remember to have ever seen an instance of the former.

Most authorities will probably decline to admit that there is any bond of connection between the two, and will aver that Graves' disease stands by itself. There are, however, few fields of pathogenetic investigation of greater promise than those in which evidence is sought which shall connect so-called *sui generis* maladies with others of common occurrence, or even with exaggerations of physiological processes. We have in the bronchoceles which occur in adolescence, and which may be quite transitory, affections which may be placed under the latter designation, and yet respecting them it is highly probable that they are often introductory to organic and persisting affections. It is further by no means proved that some slight tendency to proptosis with nervous disturbance does not usually attend these cases. It may easily be the fact that it is where the drinking of a tainted water coincides with the other

¹ See *New Sydenham Society's Translation*, vol. ii.

causes of swelling of the thyroid that the nerve symptoms become exaggerated, and pass towards minor forms of Graves' disease. Thus we cannot but think that it would be of interest to ascertain whether in districts free from the ordinary forms of bronchocele the phenomena grouped as Graves' disease are likewise unknown.

Another of the many topics of interest in connection with bronchoceles is the possibility that they may run a quasi malignant course and cause secondary growths elsewhere. This is a very rare event, but one about which there can be no scepticism. It conveys a very important lesson as regards the nature of the cancerous process. We were able to record a very remarkable example of it, and it may be that through the zeal of the members of the "Polyclinic" and the very large field of clinical observation which our organisation now covers, we shall have others brought before us. It is an important part of our work to collect facts as to rare maladies.

Nothing conclusive has been ascertained as to the precise form of bronchocele which is liable to prove infective, but it is certain that it is not one in itself characterised by any features of malignancy. It is not usually of large size and has almost invariably been present a long time. Probably it belongs to the adenocoele group. In any cases which may occur in future, the opportunity should not be lost for a very careful examination.

In illustration of its rarity we may here add that Mr. Henry Morris, whose remarkable example of secondary growths in bones consequent on bronchocele was one of the first recorded, has written us in reply to a question that he has since seen only one other example of this association. It was in a man of middle age, in whom many bones were affected. No autopsy was obtained.

TUBERCULOSIS IN SOUTH AFRICA.

SOME suggestions which have reached us lead us to fear that the remarks as to uncertainty of diagnosis with which our article on this subject in last month's journal concluded, have been understood as implying much more than they were intended to. In saying that all numerical estimates must be received with caution, and that

diagnosis and nomenclature were both open to risk of error, we did not for a moment intend to invalidate the general conclusions. There can be no doubt that the bulk of the cases which are recorded as "phthisis" are examples of tubercular disease. Our mention of pneumonia in association with phthisis was simply to note the prevalence of the two in the same regions, and to suggest as a possibility that the one might sometimes be the precursor of the other. Very few cases registered as "phthisis" are likely to have been examples of chronic pneumonia without tubercular complication. In the great majority of cases the diagnosis of phthisis may be held to have been confirmed by all the ordinary symptoms of that malady; by everything, indeed, short of bacteriological research. This conclusion was impressed upon the writer by that which is far more trustworthy than statistics, the *vivâ voce* statements of numerous intelligent and careful practitioners. There may, perhaps, be more room for doubt in the case of children than there is in adults. Cases of marasmus may in them be sometimes put down as "consumption." It is not, however, to be supposed that this possibility introduces any great amount of error, and on the whole we cannot doubt that the picture suggested by the citations which we gave, supported as they are by the general opinion of medical observers in South Africa, is a correct one.

It suggests, we may be permitted to point out, some very important questions. What has been proved is, that tuberculous disease of the lungs is very prevalent amongst the native races of South Africa. It is feared that it is increasingly so, and that it has much advanced during the last half century. This is a very startling fact, and it loses none of its significance when it is added that Europeans suffer also, though not in the same ratio, and that the disease is not restricted to any special localities, but is spread broadcast over the whole country. It seems almost absurd, in the face of these facts, to suggest that contagion from Europeans has had anything to do with it, for it occurs in places in which that has been impossible, and has not been greater near the health-resorts than elsewhere. Besides, if it were admitted that the advent of a few phthisical Europeans to Cradock, Graaff Reinet or Aliwal North was sufficient to cause the disease to spread like a plague amongst the Kaffir kraals for hundreds of miles around, the inference would be

obvious that the climate of South Africa is, to say the least of it, rather slow in exercising a beneficial control over the activity of the tubercle bacillus. As we have already stated, the disease cannot be attributed to infected milk or meat, for bovine tuberculosis is almost unknown.¹ It is also to be feared that there has been no increase in the consumption of either milk or flesh meat by the native races of late years. The reverse has probably been the fact, and greater dependence is now placed upon vegetable food—maize, millet, and potatoes—than was the case formerly. It is to this and to changes in habit as regards clothing and attention to the skin that, so far as any present facts seem to point, the greatest importance is to be attached. That the native hut offers facilities in reference to possibilities of contagion cannot be denied. The natives, however, do not spend much time in their huts, but live the greater part of the day in the open air. They are also reported by those who know them best to keep their huts very clean.

MODIFICATIONS OF SPECIFICITY IN FUNGI.

It is not, perhaps, very difficult to foresee what will be the outcome of the Commission on Bovine Tuberculosis. The ingenuity and industry of the Commission will prove well equal to the task of showing that the bacillus is the same in cattle and in the human subject, and that it can be transferred from man to ox. From this it will be easy to infer that the converse is also possible. With, however, the proof of this possibility the practical difficulty will only begin. The thing may be possible under exceptionally favourable conditions, and yet be so difficult and so infrequent that, for all practical purposes, even the possibility may be ignored. On this point we hardly expect any new light. Thus we shall be where we

¹ We make this statement on the authority (oral) of Dr. Gregory, the very able Medical Officer of Health for Cape Colony. It is supported by the expressions used in Professor Wallace's "Farming Industries of Cape Colony," who writes that "the great majority of Cape cattle may be regarded as quite without the sphere of disease," and warns the colony as to "the growing danger of importing it."

are now, and shall have to choose whichever we may regard as the less of the two evils—a certain restriction of our food-supply and a vexatious hampering of our food-producers, or an uncertain, and possibly very minute, risk of contagion. The question is by no means one to be decided solely on bacteriological grounds. The establishment of specific distinctions, difficult as it is in all departments of biological classification, is especially so when we have to deal with these minute organisms. Many facts as regards fungal life, in its larger and more easily investigated forms, would appear to show that a sort of pseudo-specificity, sufficient to interfere with the germination of spores, may easily be established by habitat. There is a fungus, the *Peridermium Strobi*, which in its æcidial stage infests the Weymouth pine. Its uredo life is passed, under the name of the *Cronartium ribicolum*, on the leaves of the red or the black currant. The proximity of these bushes (or of certain allies) is necessary to the infection of the pine. Spores may be taken from a pine, infected from some other source, and made to infect both these species of currant, and again from these two currants the pine may be infected. If this be done it will now be found that you cannot carry on the infection indiscriminately to both species of currant. The red currant will take infection only from a pine which has been infected by spores from a red currant and *vice versâ*. Thus, although the fungus remains ostensibly the same, we have proof that habitat for only a single generation has conferred upon it a sort of potential specificity. It will no longer germinate on a soil which previously suited it. We state these curious facts on the oral authority of Dr. Plowright, the distinguished author of “British Uredineæ.” Now is it not possible that something of the same kind may occur in the case of the tubercle bacillus? Its life, for even a single generation, in the tissues of one of the bovine family may unfit it for return to a human host.

Observations of great interest on this subject have recently been published by Professor Eriksson¹ of Stockholm. He finds that *Puccinia graminis*, the fungus which produces the rust on the leaves of wheat and other cereals, and which has long been known to have its æcidial form on the barberry, requires to be subdivided into

¹ See an abstract of Eriksson and Hemming's work “Die Getreideroste,” by Dr. Plowright, in the *Transactions of the British Mycological Society*, 1898.

six biologically-distinct forms or sub-species. These sub-species are determined as such by the host which, in their uredo form, they have infested. In the æcidial form they all occur on the barberry (and some allies) and present one and the same organisation; and even in their uredo form, on different members of the grass tribe, they are still morphologically indistinguishable. Their aptitude for growth is, however, not the same. The uredo which has grown on rye, for instance, will produce the æcidium on the barberry, but from that æcidium you cannot infect wheat, but only rye; and so with the rest. Thus it seems to be demonstrated that a fungus may, without undergoing any alteration of form which can be distinguished, easily acquire physiological modifications which unfit it for indiscriminate contagion. It may be plausibly conjectured that this unfitness does not amount to impossibility of transference, but only implies great difficulty.

Another noteworthy example of this kind of specialisation by habitat occurs in the instance of the bacillus anthracis. This rod-like organism may infect horses, cattle, and sheep, but as a rule it does not easily spread from animals of one of these species to those of another. If once well-established amongst sheep it keeps to sheep, and so on.

Many other illustrations of the efficiency of change of habitat—implying, of course, change of food—in effecting physiological modification might be adduced from this and other departments of parasitic life. The subject is of great interest in reference to bovine and human tuberculosis, since it shows that we must not stop short of proof that the interchange is not only possible but really common. The facts which we have stated are however by no means confined in their bearing to this topic. They suggest a doubt as to whether the forms of bacilli which are supposed to be characteristic respectively of avian tubercle, human tubercle and leprosy, are really specifically and permanently distinct. The bacillus of birds is known to be almost identical in its characters with that of leprosy, nor is that of the human subject very different. May they not be the same organism modified by habitat and food. If we mistake not, the view which would regard leprosy as clinically a form of tuberculosis is gaining ground, and it may be that bacteriologists will soon tell us the same story.

OUR ANNUAL MEETING AND OUR CLASSES.

THE third Annual Meeting of the Polyclinic was held on Tuesday, March 25, Sir William Broadbent, our President, in the chair. As the proceedings were for the most part formal, and will be fully recorded in our next Report, we need not allow them to occupy space here. The President's remarks were excellent, and the general tone of the meeting very satisfactory.

We may note with pleasure that our classes were never better filled than at present. Some, indeed, are crowded, and it has been found needful to provide supplementary ones. It is known to all who have taken interest in our career that hitherto some considerable disappointment has been felt as to our teaching classes. They did not fill as we had anticipated. We consoled ourselves with the belief that this was due to the very peculiar crisis which the profession has been passing through during the last few years. An unprecedented home-demand for qualified assistants coincided with the urgent wants of our huge South African army in exhausting the supply of medical men possessing diplomas. We had looked also to receive into our classes many men on furlough from the Services. Of these, of course, there have recently been few at liberty—hence our only half-filled class-rooms. It is to be noted that we speak only of what are called our Teaching Classes. Our Clinical Consultation Theatres have always been crowded.

It is not without interest to observe that precisely the same failure of professional auditors was experienced during the French wars in the beginning of the last century. The following is a quotation from one of the letters of Mr. Charles Bell (afterwards *Sir Charles*) :—

“I have thirty-six pupils attending my evening lectures. You may think this few, but you must recollect under what disadvantageous circumstances I began. You must take it into consideration that Carlyle is lecturing to four pupils; that Thomas, who once had a good class in the next street, has knocked under: that Chevalier does not lecture, and that Pearson does not consider it advisable to lecture this year; that Homer gives gratis lectures to the Students of St. George's Hospital—twenty-five in number—he is much delighted with the attendance. Moreover, Wilson, finding that my plan was likely to be against him, has taken it up and is now giving evening lectures on Surgery with the assistance of Mr. Brodie. An overflowing class of thirty-six is, then, not to be grinned at.”

This was written during the Napoleonic wars (1808) and illustrates well the difficulties then felt in filling surgical class-rooms in London. It was during a similar but yet more acute state of demand for professional services that the Polyclinic was commenced. Very few were at leisure for advanced study, and hence our class-rooms did not fill. Better times are, we trust, at hand.

ARSENICAL BEER AND ARSENIC—CANCER.

It appears very possible that the observation¹ that the long continued use of arsenic tends to cause cancerous processes, may attain a wholly unexpected importance. In the first instance this observation concerned only the skin, but it has since received more extended application. Although it has obtained but little attention in England, it has been confirmed in America, and to some extent in Italy. The revelations just made before the Royal Commission as to the almost inevitable presence of arsenic in all beer which is made from malt dried over coke, make it seem more than probable that for the last few centuries certain sections of the community have been habitually consuming arsenical salts. During this period coal and coke have been gradually superseding wood for the drying of malt. Now it is precisely during these years that cancer is supposed to have been increasing. During this period no doubt a considerable number of cases have been registered as "peripheral neuritis," "vagabond's melasma," "pernicious anæmia," "Addison's disease," "multiple cancer of skin," and under other names, which in reality had their origin in the dietetic imbibition of arsenic. The differences of opinion which arose in the recent cases at the Halifax Union Poor Law Hospital² are very instructive in this direction. Now if, as seems proved, the continuous use of arsenic, in small medicinal doses, can predispose the skin to multiple cancer, there seems no good reason for doubting that it may do the same for the other tissues and for mucous membranes and the viscera. It is to be regarded, in all probability, as being in almost all cases a contributory rather than an efficient cause. There must be also the constitutional tendency, the appropriate age, and in some instances the local irritation. A due recognition of these

¹ See *Pathological Society's Transactions*, vol. xxxix., p. 352.

² *Lancet*, April 26, p. 1221.

factors will serve to anticipate the easy objection that many persons have taken long courses of arsenic, and many more drunk large quantities of beer, and yet have never become the victims of cancer. A very remarkable fact which came out in the investigation of the recent Manchester epidemic of arsenical poisoning from beer, was that some of those who suffered most severely had, so far as could be ascertained, taken only very small quantities of beer. The quantities of arsenic contained in the worst specimens of beer were exceedingly small. It would seem then either that idiosyncrasy in the subject or something peculiar, and possibly variable, in the potency of the mineral in connexion with its solvent, takes a large share in the result.

It will be an interesting subject for future enquiry whether the recent supposed increase of cancer has occurred chiefly in beer-drinking populations, and whether the risk of arsenical contamination occurs in all countries where beer is made. It must not be assumed as certain that arsenic may not gain access to other articles of food, nor that other allied minerals may not possibly have similar effects. The facts which we have to keep in mind are, that arsenic can predispose to cancer, and that it may be taken unwittingly in articles of food.

THE PROPOSED ARMY MEDICAL COLLEGE.

It is impossible for anyone taking interest in the advance of medical knowledge and the higher education of our profession, to regard with indifference the scheme of the Army Board to establish a large special College in London. The proposed College will be for the training of those intended for any one of the three Services at various stages in their career, and will in addition to class rooms and laboratories probably in the end require a large Hospital. It is a well-intentioned proposal, and no one can wonder that it commends itself strongly to the non-medical mind. The nation wants for its public services well-trained doctors. Let it provide a good Metropolitan College to train them in. No course can seem more obviously suitable. Yet the problem is possibly not one to be so easily settled as it may at first sight appear to be. Excellent intentions do not always lead to successful results, and there may

be those who will doubt whether the specialisation of medical teaching for Army Medical Men is likely to work for their advantage or that of the nation. That the scheme will be very costly is, even in the present state of the income tax, no real objection, if it will be efficient. The qualities and the kind of knowledge which are wanted in the Services are in the main those that are required by the family practitioner. There is nothing which should be regarded as needing specialisation in a medical education for either. Now, London is well provided with Hospitals, and with teachers eager to teach. It has plenty of laboratories and of skilled bacteriologists. Let the War Office authorities develop their examinations to any extent, and with any degree of specialisation which they may think desirable, but it is surely a matter demanding very grave consideration whether it is desirable to found a special College, which, whilst it will compete with those already in existence, will of necessity afford only a more restricted training. The medical officer in the services will be the better and not the worse for the freest possible association, in all stages of his study, with those engaged in other departments of professional avocation.

LEPROSY AT THE MEDICO-CHIRURGICAL SOCIETY.

It may interest some of our readers to know that the subject of Leprosy is likely to come under discussion at the Medico-Chirurgical Society before the present session closes. On May 27 two papers are to be read, one by Dr. T. J. Tonkin on leprosy in the Soudan, and one by Mr. Hutchinson on the results of his recent tour in South Africa. Amongst others, Dr. Hansen, the discoverer of the bacillus lepræ, has accepted an invitation to visit England and be present at the discussion. Not improbably the debate may be adjourned after reading the papers to the second week in June. Mr. Hutchinson's chief propositions will be that the disease has been slowly and sparingly spread over South Africa by the use of badly-preserved salt fish ; that although it is undoubtedly communicable in rare instances from person to person, compulsory isolation, whilst it may obviate a few cases, overlooks the real cause of the malady, and causes much more misery than it prevents.

SELECTIONS FROM CLINICAL LECTURES
DELIVERED IN THE COLLEGE

ON THE EARLY SIGNS AND SYMPTOMS OF TABES
AND GENERAL PARALYSIS.

Delivered April 23, 1902.

BY F. W. MOTT, M.D., F.R.C.P., F.R.S.

GENTLEMEN,—I have chosen this subject because it forms part, and perhaps the most practical part, of the work which I have been doing for the last few years. The two diseases—Tabes and General Paralysis—are, in my opinion, the same morbid process attacking different parts of the nervous system, and I base this statement upon clinical and pathological observations of eighty cases of tabes and sixty cases of the tabetic form of general paralysis. Etiologically the most important by far, if not the essential factor, is the syphilitic poison. Both diseases affect males more than females; both diseases occur on an average fifteen years after infection, though the limits vary between four and twenty-five years; both diseases are unknown where syphilis is unknown; both diseases occur especially in the fourth and fifth decades. A definite history of infection can be obtained in as large a number of cases as in syphilitic brain disease or syphilitic skin disease. A considerable number of cases of married couples have been reported. In a number of these one may have suffered with tabes, another with general paralysis. Among my 140 cases there were six of such. When either of these diseases affects young people, a history of congenital syphilis can nearly always be obtained. A number of cases, about ten per cent., of tabes end in general paralysis, and about a similar number of general paralytics

in asylums show typical cord lesions of tabes dorsalis. Both diseases are, in my opinion, a primary neuronie degeneration which may commence in almost any part of the central nervous system; but we may recognise the following types: spinal, medullary, optic, cerebral.

The name tabes indicates wasting; and when we look at either the brain of a typical general paralytic, the optic nerves of a blind tabetic, or the spinal cord of a case of locomotor ataxy, the one striking feature is the wasting.

Although there is a general similarity between all cases of spinal tabes and all cases of cerebral tabes (general paralysis), yet no two cases are alike, because no two individuals are alike in temperament, nutrition, or the conditions of life under which they have lived, the complex of which has been the exciting cause of the degeneration.

A patient suffering with tabes will come to seek relief for some one of the symptoms, and not because of the definite physical signs, such as the condition of the pupils, the knee-jerks, or Romberg's symptom. And it is well, therefore, to consider what are these early symptoms. They are such as to cause pain, discomfort, interference with his business, distress to his friends, visceral disturbances, or locomotor troubles. Such patients, if they go to the Hospital, will be seen by the physician. A spontaneous dislocation or fracture will take him to the surgeon, and very possibly bladder trouble. A squint, with double vision, or failing sight, ending perhaps rapidly in blindness, will take him to the ophthalmic department or ophthalmic hospital. A fit, or mental symptoms, will take him to the neurologist or alienist.

Each of these modes of onset of the disease is indicative of a special localised degeneration of some part of the nervous system.

I will then first consider these subjective symptoms, for they may first bring the patient under your notice.

Pains.—Shooting, darting pains in the legs coming on in paroxysms, and being described as "lightning," are often thought to be rheumatic. When they occur in the thorax, they are considered to be pleurodynia or pleurisy. If shooting down the arm, especially down the inner side, as they are apt to do, associated

with sudden paroxysms of constriction of the chest, they may be thought to be anginal in origin, or due to pressure of an aneurysm. Pains I have found to be the most common early symptom, both in tabes and tabo-paralysis.

Visceral Disturbance.—A patient may seek relief for bladder trouble, even come with a distended bladder, or he is unable to pass water without considerable exertion; or he suddenly has to run to pass water owing to the slightest cough or exertion causing an escape of urine into the urethra, which sets up the reflex process. The former is due to an atonic condition of the detrusor, the latter to an atonic condition of the sphincter.

Gastric Crises.—A patient may come for paroxysms of vomiting occurring even without food in the stomach, lasting for some hours, or even a day or more, attended with great pain, perhaps constriction round the trunk. This condition I have found to be relatively frequent, and may be present without absent knee-jerks or any sign of ataxy, the reason being that the diseased process has commenced in the spinal roots of the mid-dorsal region. There are, however, certain sensory disturbances of the skin of the trunk invariably present in these cases.

Rectal Crises.—A patient may come complaining of paroxysms of pain, of tenesmus or urgency to go to stool, and a feeling as if a hot iron were being passed up the rectum. I have known a case treated for piles.

Other crises have been described, such as urethral, renal, biliary, clitoris, &c.

Increased sexual desires followed by impotence.

Laryngeal Crises are not very frequently met with, but are an early symptom in some cases. Enquiry of Dr. Bond has surprised me that very few cases come to the Throat Hospital. Sudden attacks of adductor spasm of the laryngeal muscles with stridulous breathing and dyspnoea occur, like laryngismus stridulus or whooping-cough, and in severe cases attended by epileptiform attacks. The irritation of cold air or passage of a sound will set up an attack. Usually there is some abductor paresis or paralysis.

Locomotor Troubles.—A patient may come with early signs of locomotor ataxy; he may have had the lightning pains or one of the other symptoms in a mild form, especially bladder trouble, but these

have not been of sufficient urgency to cause him to seek relief before a difficulty in walking occurred. He has noticed a swaying of his body in washing his face and a difficulty in walking in the dark or going upstairs, or he may have had a sudden giving-way of the legs, as pointed out by Dr. Buzzard.

Optic Symptoms.—A number of cases find their way to the Eye Hospital for failing vision in one or both eyes. Sometimes they do not go there until blind in one eye, for when this occurs the inconvenience to their work urges them; it is then found that they have a limitation of the field of vision and optic atrophy. This is a very early condition indeed, and patients may remain a great many years in the pre-ataxic stage. In fact, some authorities give some comfort to their patients by telling them that they may remain a long period without further serious trouble. This is true. One of the patients I saw was twenty years before developing ataxy, and he could not understand how he could have locomotor ataxy when he could walk ten miles. However, my experience shows that optic atrophy is very liable to be followed by other symptoms indicating brain degeneration. A very large proportion of the cases of tabo-paralysis in asylums are the subjects of optic atrophy, and frequently one found that the worry occasioned by their becoming blind had led to an attack of mania or melancholia, which had ended in progressive paralysis.

Double vision from a paralysis of an ocular muscle, usually in one eye, is a very common early symptom. The paralysis is usually transitory, but the double vision occasioned by a squint which may not be perceived by the patient is sufficient, on account of the inconvenience it causes him, to take him to the eye hospital. I had the opportunity thus of seeing a number of cases of very early tabes sent to me from the Westminster Ophthalmic Hospital to Charing Cross, also from Moorfields by my friend Mr. Treacher Collins.

Cerebral Symptoms.—Mania or melancholia may occur, or even delusional insanity, owing to insane interpretation of the symptoms, in a patient the subject of early tabes, and the mental symptoms may be the first which bring him under the observation of a physician.

We have next to consider the early symptoms of tabetic paralysis and general paralysis.

Seizures.—Sudden, epileptiform, apoplectiform, or migrainous attacks, accompanied by temporary, partial or complete, loss of consciousness, followed often by some form of transitory aphasia, amnesia, word-blindness or word-deafness lasting a few hours, a few days, or a week or two, may be the first indication of the disease. If the attacks are slight the patient or his friends may neglect to seek advice; indeed, these attacks may be so slight as to occasion only a slight lapse of consciousness, which the wife may tell you was “a look of bewilderment.” These slight attacks may precede a severe attack, so severe indeed that it may be considered to be an attack of apoplexy from which the patient will not recover. A few days later he is sitting up, and within a week perhaps apparently quite himself. I say apparently, because very frequently on close questioning the wife, many prodromal indications of the serious and insidious disease which will in a few years prove fatal have been observed by her. And all cases of general paralysis probably show this prodromal stage if they are carefully investigated.

Mental Symptoms.—The psychical condition of an individual, especially regarding his emotions and feelings, continually oscillates around a mean point of equilibrium. The extent of the oscillations within the limits of health depends upon bodily condition, temperament and environment. Above and below the mean point of equilibrium are grades of pleasure and of pain which are reflected to the muscles of expression, causing synergic alterations in their minute tensions. Every passing feeling is thus reflected, so that there is no art “to find the mind’s construction in the face,” but it is only the wife or closest associates who can gauge this alteration in the feelings and emotions and their reflections in facial expression. They alone have known the man as he was and as he is; still the expert, who has had a large experience of this disease, may almost intuitively, from a study of the facial expression, so suspect its existence as to make further enquiries and look for physical signs.

However difficult it is to fix the normal in the physical organism, how much more so is it in the psychical? Only those who have had the opportunity of observing the feelings and emotions, the intellect and actions of the individual closely and for some considerable time, can correctly appreciate a change of character, volition

and intelligence. Sleeplessness and nervousness are the symptoms which may bring him to the doctor in this stage.

And before making a hasty diagnosis of neurasthenia, it is well to look for objective signs of organic disease, and inquire into his subjective attitude towards those around him; for long before the patient has shown the more obvious and obtrusive symptoms and signs of the disease, the wife or partner in business, or some close associate, has noticed a change of character. Previously affectionate, kind, of an equable temperament and happy disposition, he has become subject to fits of temper, is sullen, morose or depressed, often neglectful of his wife and children; or he worries over the least trifle; accustomed to act independently, confident of his own judgment, he loses all self-reliance, and turns to others for advice in the smallest matters. He may be restless and excitable, or sullen and moping, and he has become a man of varied moods, unable to fix his attention on any subject for any period of time, or the history sometimes points to the patient having been filled with morbid suspicions, which later become fixed delusions, of persecution. The delusions or fits of temper may even impel him to attempt suicide or homicide, and the wife may be afraid of her life and that of her children. Other instances occur of quiet and sedate, even staid individuals exhibiting an antithesis of character, giving way to amusement, gambling, immorality, vice and intemperance. Sometimes the prodromal period may be marked by flashes of genius or exceptional brilliancy of artistic or intellectual power. There is always, however, a failure of concentration and steadfastness of purpose to carry the schemes to fruition. The patient may become careless about his personal appearance, untidy in his dress, forgetful of his business or his home affairs, especially in regard to events that have recently happened, his mind being absorbed by ambitious schemes which come to naught. Signs such as these may end in an attack of mania or melancholia.

Physical Signs.—There is one which, if in conjunction with one or more of the subjective symptoms above enumerated, is almost sufficient upon which to make a diagnosis, and that is the Argyll-Robertson pupils. Unequal pupils also are very suggestive. In 80 per cent. of all cases of tabes the Argyll-Robertson pupil is present, and in general paralysis it is present in about half the

cases, but sluggish reaction to light and activity to accommodation generally occurs in the remaining cases. Small pupils that do not dilate even when the patient is suffering with severe pain are very suggestive, and may be the first evidence, as I have told you, in preventing a surgeon operating on a case which was supposed to be one of intestinal obstruction but really was due to a visceral crisis.

The prodromal mental symptoms which I have enumerated, in the absence of pupil phenomena, even with a history of syphilis, would not justify a certain diagnosis of general paralysis, for all these symptoms might occur in neurasthenia.

The Knee-jerks are very early abolished in the majority of cases of tabes, but a number of cases do occur with optic atrophy or ocular paralysis or gastric and laryngeal crises in which the knee-jerk may be present and even exaggerated; as, too, in cases of arm tabes.

In some cases the knee-jerk has disappeared first on one side and then on the other, after attacks of pains in the legs. It may be present on one side and absent on the other. This may be due to the fact that the roots concerned with the sensory innervation of the quadriceps extensor muscle have not yet been destroyed on one side; or it may be due to the fact that there is coincidently a progressive degenerative change occurring in the opposite cerebral hemisphere. Such cases portend badly, for they indicate pyramidal degeneration due to changes of a similar nature to general paralysis in the cerebral cortex. In general paralysis, as a rule, the knee-jerks are exaggerated, except in the tabetic form, where there is, simultaneously with the brain degeneration, spinal cord degeneration.

Disturbances of Cutaneous Sensibility should be sought for, as they are among the earliest objective phenomena of the disease, particularly have I found anæsthesia or diminished sensibility to light tactile sensations in the thoracic region corresponding to the 4th, 5th, and 6th dorsal segments, and extending above and below this to other segments.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY HARRY CAMPBELL, M.D., F.R.C.P.

Tuesday, April 22, 1902.

Graves' Disease with Leucoderma.

ABNORMAL pigmentation of the skin is a not uncommon feature in cases of Graves' disease. It may appear in the form of a slight exaggeration of the natural tint more or less widely spread over the whole surface, or there may be a more conspicuous change, amounting even to distinct bronzing. In other instances there are localised patches of excessive pigmentation. The special feature of Dr. Campbell's case was the existence, together with areas of deep brown pigmentation (melanoderma), of districts where the skin was deficient in pigment, and therefore appeared unduly white (leucoderma). These conditions were seen on the neck, upper arms, and sides of the chest. The pigmentary disturbance showed a very high degree of bi-lateral symmetry. Dr. Campbell described two other cases of Graves' disease in which he had seen identical changes in the amount and distribution of the cutaneous pigment. It is well-known in cases where white patches appear on the skin without obvious cause—that is cases in which a nominal diagnosis of leucoderma is all that is possible—that the skin adjoining such patches usually contains excess of pigmentary deposit. In other words, it is common to find more or less melanoderma associated with leucoderma, and the question which of the two was the primary condition is not always easy to determine. This association of defective pigment with neighbouring excess of pigment is illustrated by the case recorded by Sir William Gowers, which we have previously

quoted. Further, it is quite common to find in the cases of so-called simple leucoderma that the white areas are arranged symmetrically on opposite halves of the body. The peculiarity of Dr. Campbell's cases lies in the fact that the combination of melanoderma and leucoderma arranged according to a bi-lateral pattern exists in association with Graves' disease. The fact that he quotes no less than three examples of this association forbids the suggestion of coincidence, and indeed his cases are not entirely without precedent. It must, therefore, be accepted that among the pigmentary changes found in Graves' disease there may be not only a development in the direction of excess, but also that with this may be portions of the surface where the pigment is defective. Our readers may remember that the question whether a similar state of affairs ever exists in Addison's disease has given rise to some difference of opinion. That in that disease the usual change is an exaggeration of the cutaneous pigmentation there can be no doubt, and Sir Samuel Wilks, who speaks with special authority on the subject, holds that this is invariably the case. That decision, however, has not remained entirely without comment. The question was discussed by Sir William Gairdner in the lecture delivered in the College in May, 1900. An abstract of the lecture appeared in *THE POLYCLINIC*, vol. iii., p. 17.

Other patients included (1) a case of mitral stenosis, (2) an instance of paralysis agitans, (3) a patient with "claw hand," the result of injury of the ulnar nerve produced by callus in the repair of a fracture of the lower end of the humerus.

BY C. THEODORE WILLIAMS, M.D., F.R.C.P.

Tuesday, March 25, 1902.

Cardiac Displacement in Diseases of the Lungs and Pleura.

THE first case discussed was that of a man shown at a previous demonstration, and reported in our March issue (p. 135). The condition was one of extreme pleural effusion on the right side, and it included among its consequences considerable displacement of the

heart, the cardiac impulse being found close to the left mid-axillary line. Since he attended at the Polyclinic the patient's chest had been tapped, and a large quantity of fluid withdrawn. The fluid was of a highly sanguineous character, and this necessarily gave rise to the suspicion that the case was one of malignant disease. Histological examination of the fluid, however, detected nothing to confirm this suspicion, nor did the physical examination of the chest, conducted immediately after the paracentesis, detect any evidence of tumour. Dr. Williams stated that he had occasionally met with sanguineous pleural effusion apart from malignant disease, but agreed that in the great majority of instances such fluid is of the gravest possible significance.

In two other patients the cardiac displacement had taken place towards the right side (*dexiocardia*). In each, too, the ultimate cause was pulmonary tubercle. But the immediate cause of the displacement in the two cases was very different. In one there were signs of a cavity in the upper part of the right lung. By a process of fibrosis this cavity was undergoing contraction. And the shrinking of the newly-formed fibrous tissue had led, not only to some distortion of the chest wall, but had also dragged over the heart into the right chest. The cardiac displacement, therefore, depended on fibrous changes attending tubercular disease of the right lung. In the other patient, also a young man, the physical signs were those of fluid in the left pleural cavity, and the *dexiocardia* had therefore an obvious explanation. But the history revealed certain facts which increased the interest of the present condition. It appeared that for a year or more the patient had been troubled with a cough, and had been conscious of some failure of his general health. Some three months ago, and during an attack of coughing, he was suddenly seized with urgent breathlessness and with pain in the left side. He was seen by a medical man, from whom he understood that "air had escaped from the left lung and displaced the heart." This statement, and the patient's own account of the attack, leave no room for doubt that the first cause of the cardiac displacement was a pneumothorax on the left side. His present condition confirms that view, for pneumothorax is almost invariably followed by the effusion of fluid, so that the case becomes one of hydro-pneumothorax, and it may be, that as

fluid accumulates the air gradually undergoes absorption, until ultimately the pleura is completely filled with fluid, and the condition becomes one of hydrothorax. That is the condition in the present patient. So far as the physical diagnosis goes, all that can be said is that the case is one of left pleural effusion, leading to dextrocardia. The history, however, shows that the case originally was one of pneumothorax, and that the present condition is secondary to the escape of air from the respiratory tract into the pleural cavity. Such an escape, in the great majority of instances, means pulmonary tubercle. Even in the absence of any positive evidence, a condition of pneumothorax (unless explained by a penetrating wound of the chest, fractured rib, or other injury) demands a suspicion of the existence of tubercle. In the present patient, the history of cough, and the presence of moist crepitations in the upper part of the right lung, makes it certain that the pneumothorax and the cardiac displacement are incidents in the evolution of pulmonary tubercle.

So far as displacement of the heart is concerned, the present cases show that the heart may be displaced to the right by fluid or air in the left pleural cavity, or by fibrosis involving the right lung; also that a less marked, though quite decided, degree of cardiac displacement to the left may be produced by a large pleural effusion on the right side. To these cases may be added an extreme displacement of the heart, the consequence of fibroid phthisis affecting the left lung. In this instance the cardiac impulse was detected immediately below the inferior angle of the left scapula, showing a very unusual distortion, consequent on pulmonary shrinking. The case is reported in *THE POLYCLINIC*, vol. v., p. 241.

BY WILLIAM EWART, M.D., F.R.C.P.

Tuesday, April 15, 1902.

A Case of Pneumothorax.

THIS patient, a man about 60 years of age, was presented by Mr. Douglas Wright. The fact of the existence of pneumothorax on the right side was entirely beyond dispute. The difficulty, however,

was to find a satisfactory interpretation of its occurrence. And, in addition, the practical question of treatment had to be considered. It appears that some three months ago the patient—a stout, well-developed man—when lying in bed in the early morning, turned himself in order to look at the clock, and that immediately afterwards he was seized with breathlessness and some pain in the right side. When examined shortly afterwards, manifest evidences of right pneumothorax were present, including displacement of the cardiac impulse two inches or so to the outer side of the left nipple line. This condition had been maintained without substantial change, and had only been temporarily modified by evidence of a small amount of fluid, which, however, soon disappeared. The persistence of the pneumothorax suggested that the aperture through which the air had entered the pleural cavity still remained patent, and in confirmation of this it was noted (1) that over some part of the right chest a highly amphoric breath-sound could be heard, such as would be produced by the entrance of a narrow stream of air into a large cavity; and (2) that there was a free excursion of the right chest wall in the movements of respiration.

In the majority of cases of pneumothorax due to the establishment of a communication between the respiratory tract and the pleural cavity, the opening on the surface of the pulmonary pleura soon becomes closed, either by a limited pleurisy or otherwise. Hence, after the first rush no further escape of air into the pleura occurs, and the effused air gradually becomes absorbed (see page 243) with or without the development of hydrothorax. But should the perforation in the pulmonary layer of the pleura remain patent, it is obvious that air will continue to pass into the pleural cavity with each inspiration. The pleural cavity in such circumstances is exactly in the position of an intrapulmonary cavity having a free communication with a bronchial tube. As the present case seems to be of this order, it is here that the practical difficulty in reference to treatment arises. If it were certain or probable that no further supply of air would enter the pleural cavity, it would be easy to relieve the patient of the dyspnœa from which he suffers. All that would be necessary would be to puncture the chest wall and to allow the air to escape—a proceeding which would doubtless be followed by re-expansion of the compressed lung and by return of the heart

to its normal position. But with a free opening still existing on the surface of the lung, the removal of air from the pleural cavity through a puncture in the chest wall will immediately be followed by the admission of further air escaping from the bronchial tract. Having reviewed the position in this manner, Dr. Ewart expressed himself unable to advise puncture of the chest. He approved of the proposal to strap the right side of the chest, but advised abstinence from active measures until there were signs that the communication between the bronchial passages and the pulmonary cavity had been sealed.

The other question discussed was the cause of the pneumothorax in this case. The most common cause is certainly a tubercular deposit close to the surface of the lung, which, by interfering with the blood supply, leads to sloughing of a small area of the pulmonary pleura. But the present patient had not the slightest evidence of tubercle. Until the event above chronicled he had always enjoyed good and even robust health. The same consideration appears sufficient to exclude the possibility of a neoplasm producing perforation of the pulmonary pleura. Sometimes, and without obvious cause, a limited patch of gangrene develops on the surface of the lung and leads to pneumothorax. But in these cases the rush of air into the pleura is accompanied by septic material which rapidly causes a virulent pleurisy and purulent effusion, with general evidence of septicæmia and manifest danger to life. It is obvious that this explanation will not hold in the present case, which must rather be placed among those comparatively exceptional instances in which pneumothorax occurs apart from any evidence of precedent pulmonary disease. In some of these it is probable that a former pleurisy has led to the establishment of adhesions, and that in the neighbourhood of these there have developed on the surface of the lung localised patches of emphysema. It is readily conceivable that some unusual muscular effort might lead to the rupture of one or more of these unduly distended air-cells, and that this rupture might involve the thinned pleura covering the emphysematous area. In such circumstances a pneumothorax would at once become established. In the present case, and there are parallel instances on record, there is no history of pleurisy, and therefore nothing to directly support the application of the explanation just offered. But

it is quite certain that there is pneumothorax. It is equally certain that the air has entered the pleural cavity from the respiratory tract. There must therefore have been perforation of the pulmonary pleura. The patient's history and general appearance forbid the belief that he has any serious pulmonary disease, and the non-development of pleural effusion points in the same direction. Hence we are compelled to conclude that there has been a rupture of air-cells and of the visceral pleura apart from any grave organic change, and we may therefore call the case one of simple pneumothorax. In most cases of this kind the air becomes absorbed in the course of three or four weeks, and the patient makes a good recovery. The present case is complicated by the fact that the perforation admitting air to the pleural cavity has remained open, and that it is thus impossible, either by mechanical means or by a process of natural absorption, to establish a return to the normal level of intra-pleural pressure.

Other cases included (1) a patient with ascites from hepatic disease ; (2) a case of cardiac valvular disease, with signs of a rheumatic affection of the myocardium ; (3) an instance of deficient expansion of the left lung after tubercular pleurisy, treated by respiratory exercises ; and (4) a case of phthisis benefited by the internal administration of izar, in which Dr. Colin Campbell's intra-tracheal injections of izar had also been tried.

BY JAMES TAYLOR, M.D., F.R.C.P.

Tuesday, April 8, 1902.

A Case of Syringomyelia.

THE patient, a girl of 20 years, was in the enjoyment of good general health, but the facts obtained on examination of her muscular and nervous systems proved conclusively that she was the subject of a definite organic disease of the spinal cord. The precise diagnosis was that of syringomyelia. This term is the clinical name applied to a group of symptoms arising from either one or other of two pathological changes in the substance of the spinal cord.

The first of these is a congenital condition, and consists of either a dilatation of the central canal of the cord or of an abnormal cavity existing in the grey matter and communicating with the central canal. The other central change which produces the symptoms of syringomyelia is the development of a neoplasm—glioma or sarcoma—in the grey matter of the cord, the application of the term syringomyelia to this being justified by the fact that the new growth is associated with cavity formation in its substance. It is obvious that each of these conditions must produce symptoms of the same order. In the first place, their position in or near the central part of the grey matter will interfere with the conduction of sensory impressions. For some reason not well understood this interference affects in different degrees the different kinds of sensory impressions. Hence one of the most characteristic phenomena of the disease is the more or less complete retention of ordinary tactile sensation, with the loss of the sensations of temperature and pain. This peculiarity is not uncommonly the first event to attract attention to the disease. The patient finds that he has burned or otherwise injured himself without feeling pain; or some small surgical operation is performed, and the patient makes little or no complaint. The existence of analgesia without anæsthesia should always suggest the possibility of such changes in the cord as are above described. A second result which is likely to follow the development of a cavity or a new growth in the grey matter of the cord is muscular atrophy, from pressure on the cells of the anterior cornua. Thus, at first sight, the diagnosis of progressive muscular atrophy may be suggested, but the characteristic sensory affection at once establishes a difference between the two diseases. In the third place, pressure outwards from the grey matter may be followed by more or less sclerosis in the lateral columns, and may thus lead to exaggeration of the knee-jerks and to some rigidity of the gait. Here, therefore, is some clinical similarity to multiple sclerosis—a similarity which may be further increased by the development in syringomyelia of nystagmus, as a result of the extension of the cavity upwards along the cerebro-spinal axis into the neighbourhood of the nuclei governing the ocular muscles. But, apart from other distinctions, the testing of the state of the sensation readily reveals the correct diagnosis.

In general terms, the above facts may be said to be the leading symptoms of syringomyelia, both in the case of cavity formation and in new growth. These two conditions, however, present certain differences in their symptomatology. In the first place, cavity formation is a congenital condition, though it usually gives no trace of its existence until about the period of puberty. At this time the cavity would appear to enlarge; at least, it is about this date that the symptoms due to it become evident. Tumour formation, on the other hand, has a much wider range in the matter of age. Secondly, abnormal cavitation of the cord is found practically always in the cervical region, and its extension occurs, not symmetrically, but principally into one or other half of the cord. Hence, in this variety of syringomyelia, the symptoms express themselves in the upper limbs and upper part of the trunk; and they are often unilateral in their distribution. As opposed to these conditions, a new growth may develop in any level of the cord, and may spread over a wide range. Hence the symptoms due to it will usually be bilateral, and their distribution will depend on the situation of the growth. Another important difference between the two groups of cases is found in their different rates of progress. In those dependent on cavity development in the cord the prospect is relatively good, inasmuch as the extension of the cavity is nearly always a very slow process, and it may cease to extend almost at any time. These patients, therefore, often show little or no change over a term of years, and occasionally give evidences of improvement under such measures as massage, electricity, and the hypodermic use of strychnine. But the prospects in a case of gliomatous or sarcomatous development in the grey matter of the cord are necessarily extremely grave, and the chance of the disease staying its course is of the slightest.

The facts of the case submitted by Dr. Taylor were as follows:—There was extreme wasting of the muscles of the left hand, leading to the so-called “claw hand”; another evidence of trophic disturbance was the cyanosed appearance of the hand. The condition of atrophy had developed to its present extreme degree within the last six months, but the patient had been conscious of some weakness in the limb for five years or so. About that date an abscess on her hand was incised, and she was complimented by the surgeon

on the courage with which she "bore the pain," though, according to her own statement, she felt little or no pain. The tests for sensation showed that over the left upper limb and left half of the trunk the appreciation of temperature and of painful stimuli was lost, whilst tactile sensation was only slightly impaired. There was some degree of stiffness in the gait; the knee-jerks were exaggerated, and there was appreciable horizontal nystagmus. All these conditions, it will be observed, can be explained by the existence of a cavity in the grey matter of the cervical region of the cord, the cavity having extended mainly to the left side, so as to produce unilateral muscular atrophy and sensory disturbances, having disturbed the lateral columns to such a degree as to cause in the lower limbs some evidence of lateral sclerosis, and having passed upwards to such a level as to interfere with the equilibrium of the ocular musculature.

A Case of Peripheral Neuritis of Uncertain Causation.

This case presented some likeness to the case of syringomyelia above described. The patient was a young woman; her complaint had commenced with weakness in the hands; and there had been considerable muscular atrophy and some measure of disturbed sensation. But there were conspicuous points of contrast between the two cases. The sensory defect in the patient now under consideration had been only slight in degree and limited to the three outer fingers of the right hand; muscular feebleness and atrophy, on the other hand, had been so widespread and extreme as to confine the patient to bed for nearly a year; and lastly, the patient has made an almost complete recovery. In view of this last fact the diagnosis of a central spinal lesion need hardly be entertained, and the suggestion of progressive muscular atrophy (spinal) which arose from the existence of bilateral atrophy is put out of court. Against it, even at the outset, was the fact that the knee-jerks were absent, whereas in progressive muscular atrophy they are usually exaggerated. The very considerable atrophy necessarily places the anatomical diagnosis in the lower motor neuron (spino-muscular segment), and as the spinal centres are excluded for the reasons just stated, it follows that the site of the

lesion must be the peripheral nerves. The wide distribution of the atrophy, and its symmetrical distribution, support the theory of a peripheral neuritis, with which also the loss of the knee-jerks is in harmony. The problem is to discover a cause for the peripheral neuritis. Alcohol can be confidently excluded. Neither in the patient's occupation nor in her habits is there any discoverable opportunity for poisoning by lead, nor were there any definite evidences of plumbism. Arsenic could also be regarded as a highly improbable explanation, and the absence of any brown discoloration of the skin could be urged against this as a suggested interpretation. The only positive position which could be advanced arose from the fact that the patient's illness had commenced with symptoms of sub-acute rheumatism—that is, there were pain and swelling of several joints. It might thus be conjectured that the rheumatic poison, or some poison generated in the body in the early febrile condition, was responsible for the widespread peripheral neuritis on which the patient's symptoms had undoubtedly depended. Occasionally, in quite undoubted acute rheumatism, marked muscular atrophy does occur. It is, however, rare for it to reach the extreme degree or to persist for anything like the duration of the present case ($2\frac{1}{2}$ years). Some of the muscular atrophy of acute rheumatism is probably due to reflex influences originating in the diseased joints. But admitting this explanation, there is good reason to believe that in some instances, at least, there is, as part of the manifestation of an acute rheumatic attack, a definite peripheral neuritis. This may fairly be advanced to support the theory that the present case probably finds its explanation in the manner above suggested. At all events, no evidence of a poison other than one of rheumatic origin can be discovered to account for the patient's symptoms.

Two Atypical Cases of Tabes Dorsalis.

The first patient, a woman of 43 years, complained of frequently recurring attacks of vomiting, attended with a sense of constriction or pain in the abdomen. Examination showed the pupils to be small, not quite equal, and destitute of light response. The knee-jerks were absent. There was no disturbance of gait, but the patient admitted some occasional sudden pains in the lower limbs.

Dr. Taylor remarked on the frequency with which the gastric crises of tabes dorsalis occur apart from evidences of ataxia. This, and the similarity of the symptoms, sometimes leads to a gastric crisis being mistaken for biliary colic. Regarding treatment, the only effective remedy when the attack has once developed is the hypodermic injection of morphine. The maintenance of the general health, care in diet, &c., may do something to ward off the attacks, but for the emergency itself morphine is the only effective remedy.

In the second patient, a man of 55 years, there were also Argyll-Robertson pupils and absence of knee-jerks. The chief point of interest was provided by a dislocation of the femur consequent on Charcot's disease of the hip-joint.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. HUTCHINSON.

On the Absence of Anæsthesia in Reference to the Negative Diagnosis of Leprosy.

IN the case of the boy from Demerara who attended here a fortnight ago, I drew attention to the almost entire absence of anæsthesia. He had been the subject of leprosy for three years or more, and had many patches, some of them in a retrogressive stage, but it was only in two or three places that we could get evidence of any loss of sensation, yet there could be no doubt whatever as to the diagnosis. His case may serve well to exemplify the proposition that in some cases the end-organs in the skin itself suffer much less than in others. We had long been familiar with the fact that neuritis, or destructive inflammation of nerve trunks, is present in a high degree in certain cases, hence called "anæsthetic," and comparatively absent in others, which are called "tuberous." To put it in another way inflammation of nerve trunks is not so common in cases in which the skin swells and becomes "tuberous" as it is in those in which the skin is more lightly affected. These differences are, however, only matters of degree, and they by no means establish a distinction between two kinds of leprosy.

Difficulties in the diagnosis of leprosy occur so frequently that I do not think it will be waste of our time if I ask you to allow me to read the notes of a case which came under my notice many years ago.

One morning, in December, 1886, a very vigorous looking gentleman of foreign name and aspect came into my room showing his right hand, and in a state of much nervous excitement, begged me to examine it. I found that he fancied that there was a hollow between the thumb and index finger, and he said that the knuckles were apt to get brown and dusky. On the most careful examination I could find nothing whatever amiss. He could do the scissors movement of fingers well, and sensation in his little finger was perfect. The ulnar nerve above his elbow was not thickened. I had him stripped and not a single brown patch could be found on his body, nor was there anæsthesia anywhere. He still persisted in appealing to his hand and in assuring me that there was really an unnatural hollow. I had guessed the cause of his anxiety, and on giving him a hint he at once admitted that he thought he had the early symptoms of leprosy. A younger brother was, he said, in an advanced stage of that disease, and he had himself been reading up the symptoms. Fortunately he had not got hold of the distribution of the ulnar nerve, or no doubt he would have reported numbness in his little finger.

Having assured Mr. F. that he had no indications whatever of the disease in question, and endeavoured to allay his fears, I was next interested in getting the facts as to his brother's case. They were a Jewish family, and it was known that for three generations no case of leprosy had ever occurred. They had during this time lived in one of the West Indian Islands. There were ten brothers and sisters in my patient's family, and only the one mentioned had become a leper. They had all lived much alike, and were in good circumstances. They had been accustomed to eat the fish of the district, and on the average two or three times a week. They had not been in any way, to their knowledge, exposed to risk of contagion. Mr. F. described his brother as being in an advanced stage of the malady.

I saw the patient referred to only once, and do not know whether his fears or my hopes were subsequently realised. It is to be can-

didly admitted that the early stages of leprosy often present us with great difficulties. On reading my notes again, however, I am inclined to think that my opinion was justified. If there had really been an appreciable hollow between the thumb and fore-finger—the hollow which we know so well—it would have implied destruction of the trunk of the ulnar nerve, and such destruction must have produced loss of sensation, as well as muscular wasting. You will notice also that it was in one hand only that the suspected conditions were alleged, whilst those of leprosy are usually symmetrical. This is a point, however, on which we must not rest too much confidence, for not frequently in affections destined in the end to assume accurate bilateral symmetry, one side may yet take very definite precedence of the other.

It is of interest to note that in the case of the man's brother the disease was apparently of *de novo* origin. I use the term *de novo* to mean simply that we could get no clue as to where the disease came from. The patient had had no leprous predecessors, and he had never been exposed to risk of contagion. Now it is admitted on all hands, even by the most thorough-going advocates of the contagion doctrine, that such communication is difficult, and occurs only when the intercourse has been very intimate and long-continued. When, therefore, a man of good position in society avers that he has never to his knowledge seen a leper, we may take it for proven that he has at any rate never been exposed to risk of that kind. If he had he would have known it. Yet the *de novo* cases of leprosy, understanding the terms in the sense defined, are a very large majority of the whole. The inference that the malady is produced under some influence quite distinct both from inheritance and contagion is obvious.

Congenital Aberrations of Growth, &c.

The next case which I bring before you is one in which I cannot produce the patient. She is bedridden in an asylum and the photograph is all that I can show you. The case has features of interest in several different directions. In the first place it is an example of what is called a "family disease," that is of a similar affection occurring in several brothers and sisters without any history of it in former generations. It also shews that such affections may be of

very different degrees of severity in the different individuals of the same family. A second and perhaps more important lesson is, that with an inborn tendency to local overgrowths of skin, &c., there may be associated peculiarities of the nervous system. In a lecture¹ which I gave some months ago on this subject I supported the view that in many of these cases the whole organism suffers somewhat. The subjects of such defects of external development are rarely of perfect integrity as regards their nervous system. A low condition of intelligence often attends them, and just as the skin growths may be aggressive through the whole life so also may be the depravation of the nerve functions.

We have many drawings in the Museum which bear upon these points. Those of the man Gray, whose case was well known in London twenty years ago, demonstrates the enormous multiplication of molluscum fibrosum tumours which occurred as he advanced in years. We have portraits showing his states with five-and-twenty years' interval. Our present case seems to illustrate this point, for both the tumours and the failure of intellect are still increasing.

Congenital Tumours of Skin (Molluscum Fibrosum) occurring in a Brother and two Sisters: in one associated with Defective Innervation, Aggressive Dementia and Deafness.

The illustration here given shows the state of a woman, aged nearly 40, who is in a condition of partial idiotcy. She is also covered with fibrous tumours and hypertrophies of skin. Her feet are in a condition of pes cavus. The photograph which I copy has been given me by one of our members, who desires that no names should be mentioned. He has supplied me with the following particulars. I have never myself seen the patient.

The patient's father enjoyed good health until the age of 64, when some affection of the brain and spinal cord supervened, of which he died. Her mother has always been healthy. There were six in the family—four brothers and one sister. A boy and a girl, in addition to the patient, "have tumours." One of the boys died, aged 13, of rheumatic fever, and one in infancy of bronchitis.

¹ See "Congenital Aberrations of Growth tending to Local Hypertrophies" vol. v., p. 12.

The patient is now apparently unable to speak. It is stated that she had "operations" done three or four times at Great



*Multiple Congenital Tumours of Skin, Pes Cavus and Dementia.
(From a photograph.)*

Ormond Street when she was a year old, and again some years later at University College. It is not known what was done, but as she

has a large scar over one hip, it is probable that tumours were excised. It may have been that operations were also done on her feet. Such facts as can be obtained make it probable that her condition has become aggravated in all respects as years have advanced. It is certain, however, that her state was in part congenital.

Although now deaf and apathetic, taking but little notice of anything, the woman is quite cleanly in her habits. Her urine is at times of a high specific gravity (1037), but it contains neither sugar nor albumen. The following descriptions of her external condition are in the words of my correspondent :—

“She has tumours all over—several on her forehead, a very large pendulous one on vertex, hanging down back of head; a small one on lower lip. Both ears invaded, also nose, also skin of back. The left hip shows a large scar. Right hip has tumours on it as large as oranges, and almost coalescing. Several over sacrum. Last phalanges of fingers greatly swollen, and some of the nails almost disappearing. Swellings on the feet.

“All these tumours appear to be in the skin; they are all movable, and seem to have no deep origin. A few—as on the ear—shows signs of ulceration on the surface. The discharge is offensive. Tumours are enlarging.”

Clinical Remarks in a case of Poisoning by the Medicinal Use of Arsenic.

GENTLEMEN,—The patient whom I have first to bring before you is a lady who has been under my treatment in private for seven years. Her case is a most instructive one, and we owe her our best thanks for her willingness to be made the subject of a demonstration before us. When I proposed it to her the reply was—“I will go anywhere you wish if you tell me it will be for the benefit of others.” The points which I especially desire to ask your attention to are, the condition of keratosis which affects the palms of her hands (including the digits) and the melasma of the skin of her neck. We must not ask her to undress, but you may take it from me that the soles of her feet are in much the same state as the palms of her hands, and that the skin of her abdomen is yet darker in tint than that of her neck, being, in fact, almost black. Her palms, as you see, are everywhere rough and dry, and scattered over them are numerous little horny indurations, more like corns than warts. There is no evidence whatever of papillary outgrowth, but only of epidermic

increase. Her neck from ear to collar-bone is of a deep brownish-black tint mottled with little islands of paler hue (probably scars) and shading off gradually into the more healthy skin both above and below. Her face is florid and somewhat bronzed, but it is not definitely melasmic. There are, however, some very dark freckles ("senile freckles") upon her eyelids.

Premising that the case is one of poisoning by the medicinal administration of arsenic, I will now give you the particulars of the case. It is nearly eight years since Mrs. M. first consulted me on account of lupus erythematosus of the face and scalp. I applied the acid nitrate of mercury to the patches and prescribed Fowler's solution of arsenic in four minim doses three times a day. As her home was in Yorkshire I did not see her often, and as we are not now concerned with the lupus it may be sufficient to say respecting it that whilst some of the patches on her face were cured, others continued to occur on her chest and shoulders. She was firmly impressed with the belief that the arsenic was doing them good and was therefore very desirous to continue it.

When Mrs. M. came to me on August 1 of last year, I had not seen her for three or four years, but she had during the whole of that time continued my prescription for arsenic without any long intermissions. The frequency of the dose had been varied, sometimes three times, and sometimes only twice, or even only once a day. The chief reason for reducing its frequency had been the occurrence of diarrhœa. It had never occurred to her that it was the cause of any of her other symptoms. For some years she had observed her skin getting brown, and had suffered much from tender feet. During the whole of the summer of the previous year her feet had been so tender that she had been almost wholly disabled from walking and at times could not stand. Her hands also had been tender and numb, and the palms had become dry and rough. She had experienced curious sensations of numbness with sense of enlargement in both hands and feet, the latter often feeling very heavy and as if of enormous size. She had difficulty in managing her needle, and even in buttoning her dress, and would frequently drop small objects and be unable to pick them up again. She had also experienced for a year almost continually, the symptoms of a cold in the head with some cough, but there had

been no special redness of the eyes. She had latterly lost flesh, and become very weak. I found her knee-jerks excessive rather than otherwise.

The date to which the above observations apply was August 1. I need not say I at once enjoined an absolute disuse of arsenic. Three months later, on November 18, I found her condition much improved. She had been taking *nux vomica* and small doses of iodide of potassium. Her complexion was clearer, and the palms less horny. Her feet were still somewhat numb, and were liable to become much more so when cold. Her hands also would "die" when chilled, and she was liable to sudden attacks of shivering, followed by fever. Her bowels were very costive, and she still had, almost constantly, a running catarrh. Nearly five months have now elapsed since her second visit, and it is now eight since leaving off the arsenic. Her improvement has been very great. She feels stronger, the morbid sensations in her hands and feet are much less, and condition of the skin is much less marked.

The improvement, which in this instance has rather rapidly followed the disuse of the drug, is a matter to be thankful for, for it by no means always occurs. Sometimes in cases of arsenical poisoning the symptoms continue to increase for some time after entire disuse. In several cases I have known multiple cancers continue to develop even for years after the arsenic had been disused. We can scarcely expect that the pigmentation of the skin will ever wholly disappear, for it is very deep.

The case is one full of warning for us. The dose of arsenic was by no means very large, but it was continued much too long. For that continuance I can only take to myself a share of responsibility, for the patient had not come to me for three years or more.¹ I hope no one will suggest that it is better to prescribe cacodylates or other less potent preparation, for I have not the least doubt that if such preparations are given in equally efficient doses, they are just as dangerous as Fowler's solution. The experience of recent years has furnished us with several new indications of arsenical disagreement. We used formerly to look almost solely

¹ From a note of this case, which I have discovered since these remarks were made, I find that six years ago I thought her skin discoloured and did advise her to leave off the arsenic.

to the state of the eyes, and to expect redness of the conjunctiva with pricking pain, as the warning signs. We now know that these conditions are by no means always present, and that there are others of at least equal value. A muddy state of the skin generally; pigmentation in certain regions; dryness of the palms and soles, advancing into definite keratosis; alterations of sensation in the extremities, and the occurrence of shingles; are all indications which demand caution. If you find the palms becoming horny, it is high time to desist completely and permanently, for this condition is the precursor of epithelial cancer. On this point I have often insisted on previous occasions.

Although I have said that we need not concern ourselves in the present instance with the disease for which the arsenic was prescribed, I cannot resist the temptation of pointing out that the lupus erythematosus is quite cured. On the scalp some large bald patches have been left, but on the face you cannot easily appreciate the scarring. In a few spots, little tufts of dilated capillaries remain, but these are all that we can now find. There is a strong tubercular history in the family.

Descending Lymphangitis.

Almost invariably inflammation of lymphatic trunks travels upwards. It is a peripheral sore,—on the hand or foot or elsewhere—which infects the lymph-trunks and the infection travels upwards to the glands. In the case before us the irritation has apparently taken the reverse course. Our patient is a young man in whom the whole of the left arm excepting the hand is swollen whilst suppuration is threatened in the glands above the elbow. There is not the slightest irritation to be detected about the hand or wrist; and indeed the inflammatory swelling progressively diminishes as we pass from the shoulder downwards. At the root of the neck there is a cluster of enlarged glands, and these were recognised before the arm was affected. They are not inflamed but remain loose and are very firm, they are exactly like those of lymph-adenoma (Hodgkin's disease), and in confirmation of a suspicion in this direction the man has enlarged glands in other parts—slightly in both arm-pits and very definitely in the right groin. It may be asked, Is lymph-adenoma

ever attended by suppuration? Yes, in rare instances inflammation does occur, just as it does in tuberculous glands. It may be remarked that in most cases of lymph-adenoma a large part of the advance of the disease is effected in the descending direction. Beginning usually in the neck from throat infection, it travels downwards into the chest, then through the abdomen, to make its appearance later at the groins. In some cases there is no proof of sore throat or of any peripheral ulceration as the starting point and the disease of the glands appears to be primary. This, so far as we have got, appears to have been the case in our patient. His treatment should be by arsenic and tonics and liberal diet, and if evidence of suppuration should become clear an incision must be made at once.

Hydrocele simulating Hernia.

We have had recently before us a very interesting series of testis cases: Sarcoma, Tubercular disease, and several different forms of Hydrocele, have presented important problems for diagnosis. In the present case the difficulty is suggested by the form of the swelling. When the man put down his trousers I certainly thought that he had a large inguinal hernia, for the tumour had a thick neck and bulged upwards, filling the groin and concealing the parts about the external ring. On making the man cough I was a little surprised to find that there was no expansive impulse; but as he said that he could in bed put it back the suspicion of hernia did not at once wholly vanish. His statement was, however, due to misapprehension of the question. We had noticed that the tumour was constricted across its middle so as to be somewhat of hour-glass shape. The testis was wholly concealed. It was not possible to draw the tumour down away from the external ring. It was fixed by its own tension. It was possible, however, to satisfy one's finger that it did not really pass into the ring, but only concealed it. There was free fluctuation from the upper half of the tumour to its lower part. Having in the recumbent position made quite sure of our points:—that it fluctuated; had no impulse; and did not pass into the ring; we had no difficulty in arriving at the diagnosis that it was a hydrocele and peculiar only in its shape. That peculiarity was no doubt due to want of obliteration of the vaginal canal.

We did not stop, being pressed for time, to use the light test, but advised that before tapping it this should be done. I advised tapping in the first instance and injection with iodine on a second occasion, and took the opportunity of expressing a very favourable opinion as to the efficiency of that now old-fashioned practice. I suggested that the reason why it had fallen under discredit was that usually too weak solutions were used and too small quantities left in. The mode of cure is not by causing adhesions, but by changing the secreting tendency of the lining membrane.

Tubercular Disease of the Testis; Secondary Implication of Genito-Urinary System; Question of Treatment.

The patient before us, Gentlemen, offers an excellent example of the early stage of tubercle of the testis. You see that he is a tall, lanky lad with a narrow chest, and of cachectic appearance. He knows of no consumption in his family, but his father died when he was two years old, and it may have been from phthisis. In both the testes the globus minor is enlarged and hard, and fits on the lower part of the gland as a cap. The induration is great, but it is very limited in size, the lump not being bigger than a nut. No other part of the gland or cord is in the least implicated, and there is no trace of inflammatory swelling. The diagnosis is clear.

Some of you will remember that a fortnight ago I brought a specimen of urine containing a little pus, but of which the most interesting feature was that tubercle bacilli had been detected in it. Now the condition of the testis in the patient from whom that specimen of urine was obtained was exactly similar to what is present in the patient before us. In the globus major on both sides there was a lump as big as a hazel nut, well defined, hard, and quite free from inflammation. The one case may therefore very conveniently supplement and complete the other. Our present patient may very possibly be destined to run the course which the other one has, I fear, nearly completed. It is not at all certain that he will do so, for bacilli in the testes as well as in other parts may die and thus lose their infective powers. Probably they very often, under favourable conditions, does so, but there is always a risk that they may not, or that they may rest quiescent only for a time, and then again become

active. The history of my first patient was briefly this. He was born of a mother who was the subject of phthisis at the time of her pregnancy, and who died of it two years after his birth. He ailed nothing particular in early life, but whilst a boy at school it became known that he had lumps in his testicles. These gave him but little trouble and years passed on with no failure of general health. Then at the age of 22 he began to suffer from irritable bladder, and it was found that there was a trace of albumen and a few pus-corpuscles in his urine. Subsequently the irritability became extreme, and a few tubercle bacilli were detected, in addition to the pus. It was at this stage that I was consulted. I found his testes quite free from pain or inflammation, but with the lumps in each globus which I have described. I found also, on examination by the rectum, the vesiculæ seminales thickened, and one especially very hard, almost as if calcareous. Thus you will see that there is every reason to believe that infection has spread upwards from the testes to the vesicles and prostate, and thence to the mucous membrane of the bladder, and possibly to the kidneys. Such is the ordinary route taken, and such the typical development of tubercular disease of the genito-urinary system commencing from the testes. It is a gloomy picture, but fortunately its realisation is rare. If it were common or in any sense inevitable, we should be almost as zealous to remove tubercular testes in their earliest stage as we are to excise growths of epithelial cancer. It is, however, a very serious matter to remove both testes from a young man, and inasmuch as the occurrence simultaneously of the disease in both proves strong proclivity, it is a measure by no means certain to secure immunity. There is always a possibility, perhaps even a probability, that even in the earliest stage the bacilli may have already travelled to the vesiculi, and that we may be too late. These considerations ought in my judgment, as a general rule, to forbid castration as a preventive measure in tubercle of the testes, and induce us to place reliance on constitutional measures, such as change of climate, and very liberal feeding. There may, however, be differences of opinion on this point.

REVIEWS AND NOTICES OF BOOKS.

SPRING CATARRH OF THE EYES. By Herbert Danvers, M.D. (Parma), L.S.A. (Lond.) Bale, Sons & Danielsson, Ltd., London, 1901.

THIS is a very excellent monograph and may be described as a complete study—historical, clinical, and pathological—of the disease with which it deals. The author during his practice in Italy has enjoyed exceptional opportunities of observing examples of the disease, and the results of his work are presented in this essay. The condition is very rare in England, and is the more apt therefore to be overlooked, or to be mistaken for trachoma or some form of new growth. Dr. Danvers establishes the recognition of the disease on a sound histological basis, and his clinical and microscopical illustrations effectively sustain his written descriptions. We have no doubt that his essay will be recognised as authoritative, and we heartily congratulate him, both on the thoroughness of his work and the manner of its presentation.

CATALOGUE-COMPANION TO THE MUSEUM.

(Continued from page 214.)

GROUP II.—LUPUS VULGARIS AFFECTING THE HANDS OR FEET.

No. 25 (*Original. J. H.*)—The hand of an old man in the Kensington Infirmary, under Dr. Potter's care. It was an interesting example of the association of a form of lupus on the hand exactly like lupus necrogenicus, with a tubercular family history. The back of one hand, especially over the knuckles and proximal parts of digits, were covered with hard scabs, broken into sharp points from the circumstance of their being formed over papillary growths. The disease had advanced from the back of the hand on to the digits, and had

left a scar behind it. The process had not been attended by any material inflammatory swelling, and the crusts which had formed were quite dry. The man was 71 years of age, and he said that the disease had been present five years. He had been a mason by occupation, and did not think his hand had ever been exposed to risk of contamination with animal matter. He had lost no fewer than five of his children from phthisis and another was, at the time the portrait was taken, an inmate of the Consumption Hospital at Brompton. The man, although he did not look his years, had a cough and might be the subject of senile phthisis.

This form of lupus would appear to be frequently a senile disease. Several of the portraits showing lupus on the back of the hand are obviously from elderly people: one, at least, of those published by Hebra, shows the withered skin of old age. In the present instance probably the exposure of the man's hand to cold and to external irritants has been the means of locating the disease.

No. 26 (*Hebra's Atlas*).—A portrait taken from Hebra's Atlas showing the usual conditions assumed by lupus when it attacks the hand. The disease has spread over the whole of the back of the hand, wrist and fingers. There is a thin scar in the middle, but everywhere at its edges the parts are swollen, inflamed, and covered by a pus crust. It is an example of "lupus exulcerans," or in other words, of inflamed lupus, occurring on a part liable to exposure to cold and irritation.

No. 27 (*Cazenave's Atlas*).—A portrait, taken from Cazenave's Atlas (plate 47), showing inflamed patches of lupus on the back of the hand and forearm. The patches are covered by thick, dirty, pus-crusts. M. Cazenave's name for it is "Lupus Ulcéreux Hypertrophique"; but the last adjective does not appear to be specially applicable. The conditions are those commonly seen in lupus of the hand when neglected, and as shown in other portraits in this series.

No. 28 (*Original. J. H.*).—The portrait of a foot, showing a patch of lupus ulcerated and much inflamed, as it frequently is when it occurs in this position. The patient was a young lady, aged 15, who was under care in 1884. The disease had commenced, many

years before, over the root of the middle toe, and had gradually extended upwards. Miss M. presented no other appearance of struma, and appeared to be in good health. There was not the slightest reason to suspect syphilis. It will be seen that the edges of the ulcer are characterised by the formation of firm bossy masses of granulation tissue. Small satellite patches have been developed in several directions, but in none is the condition known as apple-jelly infiltration to be identified. In its ordinary condition the ulceration was covered by an adherent crust—this had been cleared away for the advantage of the artist. The disease was treated by caustics, and a good cure resulted. She was seen many years afterwards in good health.

No. 29: K.—T¹ 208. The arm of a young person, showing large patches of inflamed and crusted lupus on the back of the hand, on the forearm and on the upper arm.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris brachii.*”

No. 30: from Crocker's Atlas. The back of the hand of a young person, showing a patch of inflamed lupus crusted at its borders and cicatrised in the middle. The conditions are very similar to those shown in Kaposi's portrait just described. It is designated lupus papillomatosus, but there is nothing shown of a papillomatous character.

No. 31: K.—T. 209. A reduction from one of the plates in Hebra's Atlas. A very large patch is seen involving one thigh. The appearances are suggestive of a syphilitic form of lupus. The curved edge is narrow and there is a very large thin scar.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris serpiginosus exulcerans femoris.*”

No. 32: K.—T. 210. The elbow and back forearm occupied by lupus ulcers and scars.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris exulcerans et fungosus.*”

No. 33: K.—T. 207. This portrait represents a very unusual condition of lupus vulgaris. The scalp is involved and the hair

¹ The letters K.—T. stand for Kaposi's Atlas, Tafel —

destroyed over a very large extent. Both buttocks are covered with lupus-ulceration which meets across the middle line. They are œdematous and almost in a state of elephantoid hypertrophy. Patches of lupus are also seen on the back of the right leg and on the right arm and hand. The left lower limb is much shortened as if from disease of the hip-joint. The patient is probably a young adult man. In spite of the involvement of the scalp, as in lupus erythematosus, no one will doubt that it is correctly named lupus vulgaris. As illustrating implication of the scalp and destruction of hair it affords an important connecting link between the two forms.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris regionis occipitalis, extremitatum tumidus et deformans, ad nates c. elephantiasis Arabum subjacente.*”

No. 34 K.—T. 212. The right lower extremity and genitals of a young man showing many and large patches of lupus. The patches have congested and evidently aggressive borders. The skin of the penis and of the scrotum is involved. In these respects and in the multiplicity of the patches the case resembles that of the boy, Llewellyn, but unfortunately we have no information as to the conditions in other parts.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris scroti penis inguinis cruris pedis dorsi.*”

(To be continued.)

CORRESPONDENCE AND ANSWERS.

BEER DRINKING AND THE INCREASE OF CANCER.—A very significant fact in reference to the suggestion made at page 231 that the drinking of arsenical beer may have had something to do with the recent increase of cancer, is that the increase has been greater amongst males than females. The Registrar-General tells us that cancer is now twice as common in men as it was thirty years ago. It has increased in women also, but not in anything near the same ratio.

* * *

ON SUDDEN GREYNESS OF THE HAIR.—In connection with the article in our last issue (p. 112), we quote the following from a lecture on metallic poisoning by Sir Wm. Gowers, published in the *Lancet*, November 2, 1901 (p. 1175). After

referring to the existence on the skin, pigmented brown by the action of arsenic, of white spots which appear to have lost their normal pigment, the lecturer continues: "Why such areas should not only resist the pigmentation but should apparently lose what they possessed, is a mystery which the pathologists have not, I think, explained. But we may note that there seems to be a curious solidarity in these pigmentary processes, in consequence of which excess may entail adjacent deficiency, and, I may add, a deficiency may be attended by adjacent excess.

"Perhaps you will allow me to digress for a moment to mention to you a very remarkable illustration of the latter fact—increased pigmentation in the vicinity of its diminution. I have described the case elsewhere, but it will probably be new to you. It is that of a man who had traumatic meningeal hæmorrhage over the left hemisphere. As a result of this, during the three days he lived after the injury, the right, opposite half of his brown moustache and beard became blanched so as to be almost white. The hair of the scalp was not affected. The change was watched during life and carefully noted after death. It was like that which has been described as the result of profound emotion, but it was due here to a physical agency. It can only be explained by assuming that the disordered innervation so changed the secretion at the roots of the hair as to produce a material capable of ascending the hair and discharging their pigment. But after death we noticed another thing, which leads me to mention the case. The very grey, almost white, right half was separated from the natural brown left half by a narrow vertical line, or narrow zone, in the middle line, in which the hair had become almost black. Apparently where the disordered influence ceased in its extreme degree, at the blending of the innervation of the two sides, a change in the pigmentary process had occurred of the opposite character. Mysterious as the fact is, and perhaps impossible to explain, it illustrates the close relation between the *plus* and the *minus* in pigmentary processes. I am not sure that we may not find another illustration of this in some cases of atrophy of the pigment of the choroid adjacent to a spot at which it is collected, and also in the heaping up of pigment in association with areas of atrophy. But this may have another explanation."

* * *

HUXLEY ON TRUTHFULNESS AND HONESTY OF THOUGHT. — "The last thing that it would be proper for me to do would be to speak of the work of my life, or to say at the end of the day whether I think I have earned my wages or not. Men are said to be partial judges of themselves. Young men may be; I doubt if old men are. Life seems terribly foreshortened as they look back; and the mountain they set themselves to climb in youth turns out to be a mere spur of immeasurably higher ranges when, with failing breath, they reach the top. But if I may speak of the objects I have had more or less definitely in view since I began the ascent of my hillock, they are briefly these: To promote the increase of natural knowledge and to forward the application of scientific methods of investigation to all the problems of life to the best of my ability, in the conviction which has grown with my growth and strengthened with my strength, that there is no alleviation for the sufferings of mankind except veracity of thought and of action, and the resolute facing the world as it is when the garment of make-believe by which pious hands have hidden its uglier features is stripped off."—"Autobiography."

THE POLYCLINIC

BEING THE

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ARSENIC IN ARTICLES OF FOOD.

It most certainly behoves the British profession to bestir itself in the investigation of the arsenic question. Perhaps that duty more especially concerns our Polyclinic members, since we have an organisation for the collection and publication of facts. Our duty in the matter lies in two directions—first, to guard the public against needless panic, and, secondly, to ascertain what the grounds for anxiety really are. When it becomes a matter of general knowledge that all beer made from malt dried over coke is liable to contain arsenic, and that a host of nervous affections, and possibly even cancer itself, are attributed to the long-continued taking of that mineral in small doses, there will certainly be much public alarm. It will be for us to explain that there is also a bright side to the shield. We may truthfully point out that during the period with which our observations are concerned, *i.e.*, the last century, the general health of the community has been improving, and that the duration of human life has been steadily increasing. We may with great confidence claim for arsenic that, in medicinal doses, it possesses most remarkable powers in the control of many very serious diseases. We may also suggest that, in the much smaller doses in which beer-drinkers usually receive

it, it is simply a very efficient tonic, and that thus, although some may have suffered from arsenical beer, a large majority have been benefited. If a balance-sheet showing gains and losses could be struck, the advantage might still be found—even with the fearful item of a cancer debit—largely on the right side. Cancer is a disease chiefly of senile life, and it may be that arsenic has assisted many to attain that age who would not have done so without its help. To those to whom such considerations may seem to bring but cold and rather doubtful comfort, we may urge that the ill results, now that we have become aware of their existence, are easily avoidable.

There need in future be no risk that our beer should contain more than very infinitesimal quantities of arsenic, and when the indications of disagreement are more widely known the cases may, it is hoped, be but few in which the patient is not warned to stop in time. Meanwhile it may be safely held that zeal to exclude infinitesimal quantities from articles of diet may overshoot the mark.

It may be well here to advert briefly to the symptoms which ought to excite alarm and lead to enquiry.

Perhaps the most definite of the many and varied symptoms which we now associate with the internal use of arsenic is Herpes Zoster. When, forty years ago, it was first observed at the Blackfriars Hospital for Skin Diseases, where arsenic was very freely used, that many of the patients who were taking it got attacks of shingles, the occurrence was thought by most to be a mere coincidence. The fact, however, of there being a causal relation between the two is now recognised by all Dermatologists, both at home and abroad. Now, shingles is a very conspicuous malady, about the diagnosis of which there can be no mistakes; and it will become an important subject for enquiry as to what has been its relative prevalence at different places and in recent times as compared with former ones. It is true that it is rare in connection with arsenical poisoning; but still the facts justify us in believing that no epidemic of such poisoning could occur without producing it in much excess of what is usual. It was the frequency of shingles which first aroused suspicion in the recent outbreak at Manchester.

All forms of peripheral neuritis ought also to excite suspicion. Numbness in the soles of the feet or in the regions of distribution of any special nerves come into this category.

Our consultation theatres at the POLYCLINIC will always be available for the investigation of any such cases in which there may be doubt.

SYPHILIS IN CAPE COLONY.

ALTHOUGH Syphilis had probably its home on the West Coast of Africa, and was from there imported by the Portuguese into Europe, there is reason to believe that Europeans have in turn been responsible for its introduction into the southern part of that continent. There is no evidence of its existence amongst either the Hottentots or Kaffirs prior to their subjugation. Nor did the primitive state of society which existed under Dutch rule much favour its spreading. Under that regime, arrangements almost equivalent to polygamy were common enough and illegitimate births were abundant, but prostitution and syphilis were little known. It has been reserved for the more advanced stage of civilisation under our own sway to stand sponsor for the advance of syphilis amongst the native tribes. At the present time Cape Town and Johannesburg are the chief centres from which it spreads, although many other of the larger towns, especially those which attract large numbers of labourers, must take their share. The conditions of home life amongst both Kaffirs and Hottentots are, irrespective of immorality, such as to favour the spread of this contagious malady by mere carelessness. Hence it not unfrequently happens that a man who has been to work at some port or mining centre, and has there contracted syphilis, may take it home with him and become the focus of a family- or even a village-outbreak. That is briefly what has been occurring all over South Africa for the last fifty years. The disease has maintained its hold with very different success at different places. In some it has no doubt been reinforced from time to time, and in others it has been more or less effectually combated.

There is in Cape Colony a Contagious Diseases Act, under which, with variable efficiency at different places, prostitutes and others suffering from syphilis may be brought under treatment.

In many districts there are small hospitals—which by the way are often called Lazarettos—into which those suffering may be received. To these, frequent reference will be made in the extracts which we are about to place before our readers. These extracts are from the published Annual Reports of the District Officers of Health. These officers are required every year to report as to the prevalence of certain specified diseases in their districts, and it was from them that we took the extracts in relation to Tuberculosis which were given last month. As was then admitted, such extracts are merely fragmentary, but they are nevertheless of a value at least equal to that of most so-called statistics. They are, moreover, the best statements of fact that are accessible to us.

Before proceeding to produce these, the writer may perhaps be allowed to record the results of his own personal observations. During a recent short tour in the districts concerned, he made it his duty to enquire of the numerous medical men with whom he was brought into contact, as to their experience of syphilis, and he also visited some of the hospitals in the principal towns. One of the first questions which it was needful to ask was whether any diagnosis was attempted between Syphilis and Yaws. To this the almost invariable answer was in the negative. Dr. Long, of Maseru, in Basutoland, stated that when he first went into the Colony he had been accustomed to make a distinction, but he had become convinced that all the cases of so-called yaws were really syphilis. In one hospital the writer was shown a case of “yaws” in a Hottentot. The man had a well-characterised frambœsial eruption over the whole body, which was disappearing in the usual manner in which such eruptions do. He was taking mercury, and he still had on his prepuce the well-characterised remains of a hard chancre. Another informant mentioned a series of cases in a Kaffir kraal in which vaccination had been the means of initiating “yaws.” A large number of persons had been infected. The eruptions appeared to have been deemed characteristic, but in no other feature did there seem to have been anything to distinguish the outbreak from one of vaccinal syphilis. No other facts in relation to yaws were brought under the writer’s notice, and the general impression seemed to be that as regards South Africa it is a non-recognised malady. There seemed reason to believe, however, that in the dark

racés of the Colony, as elsewhere, the secondary eruption of syphilis much more frequently assumes the framboésial type than it does in Europeans.

As regards syphilis, reports, as might be expected, varied much. There was a general consensus in the opinion that although in some cases very severe, the disease, on the whole and in the average, is a much milder one than in Europe. The natives think but little of it, and often neglect treatment; and the cases which come under care are usually very amenable to specifics. Many thought that the disease was becoming milder, and were inclined to attribute this amelioration to the now almost universal treatment by small doses of mercury long continued. Others, however, thought that even without treatment the disease in natives was usually a mild one, and that in Europeans the climate was one very favourable to the successful management. There was absolute unanimity as to the efficacy of specifics, and almost so as to preference for administration by the mouth over other methods. Everyone, indeed, seemed quite satisfied with the modes of treatment at present employed, and regarded the malady as one easily curable, if only its subjects would come under treatment.

The occurrence of non-venereal contagion was mentioned as being common amongst the natives, and several painful instances were mentioned in which coloured girls employed as nurses in European families had infected children under their care. Everywhere the advantage of having homes in which those suffering from the disease in its most contagious conditions could be secluded and treated was spoken of with the most warm approval.

With these preliminaries in explanation, the following extracts may perhaps be best left to tell their own story. They concern Cape Colony and the Native Territories only, and do not include Natal.

Cape Town, Johannesburg, and some other of the larger towns may for the present be omitted, since it is acknowledged that in them prostitution and syphilis are common. Simon's Town (the naval station in False Bay), East London, and Port Elizabeth, are all ports and frequented by sailors. In all of them there are Lock Hospitals, and in all the Contagious Diseases Act is enforced with more or less strictness.

From Simon's Town, in 1896, Dr. H. Clarke reported that during

the year sixty-three women had been dealt with, and there had been thirty-four admissions into the hospital. At Port Elizabeth Dr. F. Ensor reported the periodic examination of 130 women, of whom forty-one were stated to be European, and thirty-nine coloured. At East London Dr. Paley, in a special report, recorded that syphilis was prevalent.

The places which we have now to mention are all situated inland, and are mostly of much smaller size, many being quite rural districts. It will be seen that the reports as to the prevalence of syphilis vary very much, and without any very obvious explanation. For the British observer it is of interest to note the invariable approval of segregation hospitals and the desire to obtain them where not yet provided.

From *Steynsburg* (north of Cradock).—Dr. Vermaak, in 1897, reported that

“A hospital for syphilis is much needed.”

From *Albert*.—Dr. Young, in 1896, reported that syphilis was believed to be on the increase amongst natives.

From *Beaufort West*, on the northern border of the Great Karroo, Dr. A. J. Westry, in 1898, reported:—

“Syphilis is greatly on the increase, both in town and district; and I would strongly urge that more stringent means be taken for its suppression.”

In his report, in 1897, from *Peddie* (near Grahamstown), Dr. Arenhold spoke of the need of an isolation hospital for syphilitics.

Of *Riversdale*, Dr. J. W. de Vos wrote, in 1898, that syphilis was decidedly on the increase.

Knysna, near Mossel Bay.—Dr. Clifton. Twenty-two patients in twelve different families had been under treatment at the City District Hospital.

“Which number, compared with those of former years and taken into conjunction with the character of the cases, goes to show that venereal disease may be deemed satisfactorily under control in the district.”

Humansdorp (west of Algoa Bay).—Dr. Coulston reports, in 1898:—

“I have never seen or heard of a community so thoroughly rotten with syphilis as the Hottentots and half-breeds of Hankey and the Gamtoos River seem to be. It is seldom, on asking one if he has had it, that you get any answer but ‘Yes, some ten to six years ago.’ There seems at that time to have been a regular

plague of it prevalent in the district; and now you see the victims with the most horrible results of the tertiary stage that I have ever met with. The effects are also seen in the number of babies one comes across with the hereditary form of the disease, and from the frightful mortality (about 50 per cent.) occurring among the Hottentots and bastard children of one year old and under. There are, of course, cases among both Europeans and Fingoes, but the majority are among the Hottentot and bastard population who go largely to Port Elizabeth as servants, where I fancy they contract the disease, and returning home spread it among their friends and relations, of course with the result that now and then a white child gets it from its nurse."

Malmesbury.—Dr. Roux writes:—

"Syphilis has practically died out. It was very prevalent twelve years ago, but now only an occasional case turns up from the country districts."

Piquetburg, north of Malmesbury.—Dr. Smuts writes:—

"There have been comparatively few cases of syphilis this year. Several of the Namaqualanders however, who passed through the district to Cape Town and elsewhere were supplied by me with iodide of potassium for long standing specific disease. The transit of these people through our district is undesirable in every way."

Dr. Piper had attended more than a dozen syphilitic cases mostly amongst the coloured population.

Fraserburg, north of the Great Karroo (31° lat., 21° long.).—Dr. Mader, 1897. The report refers to a good many cases of syphilis, and expresses the opinion that it is increasing. The surgeon to an adjacent district also refers to several cases, but expressly states that they came for treatment from other districts, and that he was not aware of any originating in his own.

Graaff-Reinet (1897).—Dr. Hudson mentions that a number of cases of syphilis, in its most contagious stage, had to be refused admission to the Isolation Hospital, owing to lack of accommodation therein. Dr. Shire mentions two European children suffering from syphilis, probably from infection by their nurses.

From *Willowmore*, a district south of Graaff-Reinet, Dr. R. M. Townsend reported:—

"I have endeavoured to investigate every case of reported syphilis, which is somewhat prevalent in this district, among Europeans as well as Hottentots. I may here say that I think more stringent regulations should be enforced with a view to detection and treatment of this disease. Europeans conceal as much as possible, and Hottentots think it desirable that their children should be 'salted.'"

From *Philipstown*, on the borders of the Great Karroo, Dr. Hugo reports that he has recently found syphilis very prevalent amongst

the native population, and demands an isolation hospital for its efficient treatment.

Kenhardt is a thinly-populated district to the far north and west of the Colony, near to Namaqualand, and in what used to be known as Bushmansland. Dr. Meir, the medical officer in 1897, spoke of "various kraals of Hottentots and Bushmen" (?) concerning which he felt morally sure they were "nests of syphilis." The chief hospital of his district was, he said, "a disgrace to a civilised country."

From *Kuruman* (beyond Mafeking), 1897, Dr. Beare reported :—

"This district includes a large prison in which about one hundred syphilitic patients have been treated."

Oudtshoorn, Sub-district Calitzdorp.—Dr. C. M. Corkery reports for 1896 :—

"During the year seventeen fresh cases were put on this register, as against nineteen during the year 1895, and while thirty-four patients were reported as continuing under treatment on January 1st, 1896, only twenty-seven are now continuing attendance. Still more satisfactory is the fact that not a single new case of infection has come under my notice amongst the whites during the year."

Dr. R. W. Watson, in his reports for 1896 for *Ladismith*,¹ says :—

"The prevention of syphilis and the provision of proper accommodation for patients require immediate attention. The number of cases has increased from twenty-one in 1894 to thirty in 1895, and fifty-nine in 1896; thirty-six of these were under fourteen years of age. While the parents are away at work the healthy and sick children play together, and are often sent to school to keep them out of mischief; at night they all sleep in the same room. Four white children have been infected from coloured nurse girls. Syphilis is often concealed from the fear of the parents losing their work. If something is not done Syphilis must spread to a still greater extent next year."

From *Mossel Bay*, not far from Simon's Town.—Dr. Thomas Ketchings reports that treatment of syphilitic cases is anything but satisfactory for want of control.

From *Montagu*.—Dr. Joseph Castles wrote in 1897 :—

"There is no syphilis in this district."

From *Colesberg* (south of Bloemfontein).—Dr. James Key writes :—

"Tertiary syphilis is common in all the older coloured population, but primary is rare and always imported."

¹ Ladismith, Cape Colony, must not be confounded with Ladysmith, Natal.

In 1896 Dr. Riordan wrote:—

“Syphilis appears to be on the increase here. A proper hospital is urgently desired for the treatment of syphilitic paupers, and other forms of contagious disease.”

Colesberg: Dr. R. de B. Riordan:—

“Syphilis is not so prevalent here now as it was some years ago. Norval’s Pont station appears to be the centre of syphilis in this district, but on the whole syphilis is on the decrease here.”

Vryburg (the capital of Bechuanaland).—Dr. Chas. Brown, 1899, reports:—

“I must now point out the terrible prevalence of syphilis of a very severe type amongst our native population. It may be calculated that 20 per cent. of the natives are more or less affected with this disease, and there is urgent necessity for a C. D. Hospital. The stamina of the whole native population is becoming slowly and surely undermined by this pest, and it prevails amongst all classes of natives, not necessarily spread by actual venereal contact, but by careless habits in eating, drinking, and mixing together.”

The following extracts concern what is called *the Native Territory* and districts near to it. Into these regions the disease is of comparatively recent introduction.

From *Tsomo* we have the statement—

“Syphilis appears to be increasing rapidly amongst the natives, the disease being now largely imported from the goldfields; my last request for Government aid in this matter was met by the reply that ‘no funds were available for the purpose.’”

From *Griqualand East* in 1896.—Dr. Perkins, speaking of the Maclear district, gave an excellent account of the general health, and stated that he knew of “only two syphilitics, unfortunately both white children, who had acquired the disease from native servants.” Such an occurrence suggests, however, that there must be a good deal amongst the natives.

In 1893 Dr. J. C. Holding reported of an adjacent district:—

“I am acquainted with only four persons suffering from syphilis at the close of the year, which shows that the latter disease is rapidly decreasing.”

In 1894 Dr. Holding wrote:—

“I am pleased to remark that syphilis is rapidly decreasing in this district. Not a single case has come under my notice during the year, and I have failed to discover any person suffering from the contagion. The few cases of 1893 appear to have left the district.”

Glen Grey.—Dr. W. S. Park:—

1896.—“During the year there has been a distinct decrease of syphilis.”

1897.—“Syphilis has considerably decreased during the year ; ten cases were attended, and two of gonorrhœa, one case of syphilis remaining under treatment. In 1896 there were twenty-one cases of syphilis ; in 1895 there were thirty-three cases ; in 1894 there were fifty-three cases.”

From *Mount Frere*, a district in the east of the Colony.—Dr. F. G. Butler, in 1896, reported :—

“There are many cases of syphilis. I would suggest that this district have its own hospital.”

From *Mount Curry* (not far from Mount Frere).—Dr. Thornton, 1897, reports that a considerable number of cases of syphilis and gonorrhœa had come under his notice, and urged that an isolation hospital ought to be built.

The above two districts lie to the north of what is known as the Native Territory.

The extracts which we have thus somewhat lengthily given will, we trust, afford our readers a vivid picture of the very irregular prevalence of syphilis in Cape Colony at the present time. They show how, in country districts, the disease often spreads by non-venereal contagion, and also in a most instructive manner the confidence which is felt in the provision of isolation homes as a means of preventing such contagion. Repeatedly do reporters from different districts speak of diminished prevalence, and use such expressions as “having got the disease under control.” At some future opportunity we may have to make some remarks on the suitability of such arrangements for our home population. There is, however, in the Colony less of prejudice and more of common sense in this matter than we in England can boast of.

AGE IN REFERENCE TO CANCER.

It has been sometimes asserted that the proclivity to cancer is greater in the period immediately succeeding middle age than it is in old age. A short table given by Dr. Tatham in an interesting paper in the last number of the *Dublin Journal of Medical Science* seems to entirely dispose of this fallacy, and to make it quite clear that the more senile the organism the greater is its proneness to cancer.

Rate of Mortality from Cancer in England and Wales, at certain periods of life, in each Sex, A.D. 1900.

									ANNUAL DEATH-RATE PER 1,000,000 LIVING AT EACH AGE.	
									Male.	Female.
All ages	...	...	...	...	...	...	...	...	672	975
Under 35 years	...	...	...	...	...	...	...	...	44	66
35-45	...	...	...	...	...	...	...	...	418	924
45-55	...	...	...	...	...	...	...	...	1,483	2,433
55-65	...	...	...	...	...	...	...	...	3,796	4,561
65-75	...	...	...	...	...	...	...	...	5,735	6,254
Above 75 years	...	...	...	...	...	...	...	...	6,715	7,468

Thus we see that of those living, under the age of 35, only one hundred and ten per million will die each year from cancer, whilst of those living above the age of 75, no fewer than fourteen thousand will so die. We learn further that the liability to it goes on increasing with each decade. Thus the decade 55 to 65 had a ratio of only 8 to 12, as compared with what it was in the next. This is a most important demonstration, and definitely places senility of tissue in its proper place as a predisposant to malignant action. Thus we see that—as has often been pointed out before—the increase in average longevity which has characterised the last century has probably taken an important share in the increase in the mortality from cancer which has also occurred.

MULLEIN MILK IN PHTHISIS.

SOME years ago, Dr. Quinlan, of Dublin, a good authority, interested himself in the advocacy of a decoction of the leaves of the common mullein (*Verbascum thapsus*) for tubercular disease.

The recommendation was not new, for an allied plant was known to herbalists as "Bullock's Lung-wort," on account of its supposed virtues in that direction in cattle; and Dr. Withering tells us (1830) that it had special repute in Norway. Dr. Quinlan gave it as a decoction in milk. Three ounces of the fresh leaves were to be boiled (for a minute) in a pint of milk, and after straining and sweetening the whole was to be drunk. As this dose was to be repeated twice or three times a day, it is possible that the two or three pints of milk should be credited with part of the fattening properties which are claimed for the herb. As it is said to be pleasant to take and to be efficacious against both cough and diarrhœa, it may be worth a trial at some of our now numerous sanatoria for phthisis. That mullein is not inert seems probable from the statement, also on the authority of Dr. Withering, that it will intoxicate fish. Most animals decline to eat it.

THE DISAPPEARANCE OF LEPROSY FROM IRELAND.

AT one time leprosy was prevalent over many districts in Ireland. There were homes for lepers in various places, chiefly near to the larger towns in the east. The disease gradually died out, and during the last two centuries only imported cases have been witnessed, with the single exception of the often-quoted case which was recorded by Dr. Hawtrey Benson. Dr. Byers, of Belfast, has kindly supplied us with very interesting details as to the location of the leper houses, and the conditions under which the disease declined. To this subject we shall probably recur at some future time. For the present we must be content to give only a single extract, which is from the pen of a physician of much distinction in the times in which he lived.

With reference to the prevalence of leprosy in Munster, Dr. Boate was struck with the fact that in his time, 1652, leprosy had almost ceased to exist, and the hospitals, which had been so common, "had decayed and come to nothing." He was evidently exercised in his mind to account for this very remarkable change, and the

following quotation from his "Natural History of Ireland" is, we think, of very great interest: "The cause of this change is not so obscure nor unknown, as it is in most other changes of that nature. For that this sickness was so general in Ireland, did not come by any peculiar defect in the land or in the air, but merely through the fault and foul gluttony of the inhabitants in the successive devouring of unwholesome salmons. The common report in Ireland is, that boiled salmons eaten hot out of the kettle in great quantity, bring this disease, and used to be the cause why it was so common; and some famous authors have not stuck to relate as much for a truth. But that is a fable, and salmons have not that evil quality, which way soever they be eaten and prepared, but when they are out of season, which is in the later end of the year, after they have cast their spawn; upon which they do not only grow very weak and flaggy, but so unwholesome that over their whole body they break out in very filthy spots, just like a Scaldman's head, so as it would loath any man to see them; nevertheless the Irish, a nation extremely barbarous in all the parts of their life, did used to take them in that very season as well as at any other time of the year, and to eat them in very great abundance, as easily they might, every river and rivulet being very full of them, and by that means that horrible disease came to be so common amongst them. But the English, having once gotten command of the whole country into their hands, made very severe laws against the taking of salmons in that unwholesome season, and saw them carefully observed; whereby hindering those barbarians against their will to feed on that poisonous meat, they were the cause that that woful sickness, which used to mightily reign amongst them, has been quite abolished" (p. 101).

THE BROTHERS BOATE.

THE following fragment of Medical Biography may be of interest to some of our readers. Dr. Byers, from whom we receive it, writes:—

I am indebted to Dr. Reeves, Bishop of Down and Connor, for

the following account of the distinguished Dr. Boate: "Arnold and Gerhard Boate were two brothers who came to Ireland before the middle of the seventeenth century. They were Dutchmen by birth, and had studied physic at Leyden. The former was a very learned theologian, and several of his letters to Archbishop Usher, and of Usher to him, are printed in the sixteenth volume of Archbishop Usher's works. He lived over eight years in Dublin, and preached there with success. His first letter to Usher is dated Dublin, November 15, 1639, and his last, April, 1653, from Paris, where most of his letters were written. His brother Gerhard completed from hearsay 'Ireland's Natural History.' Writing from Paris, Arnold says: 'Although my Brother hath been in Ireland and that he hath ended his days there, yet he had both begun and finished the First Book of his Natural History some years before he went thither, or had any thoughts of doing so: seeing that he began to write that work in the beginning of the year of our Lord 1645, and made an end of it long before the end of the same year; whereas he went not to Ireland until the latter end of the year 1649, and died at Dublin within a very short while after he was arrived there only: on the 10th of January, 1649,' &c., &c.

"Previously to his death he had been appointed to the post of State Physician. The work was not printed till 1652, when it was published in London by Samuel Harlit. Chapter XIV., Section 4, treats 'Of the Leprosie.' I should mention that Arnold was, long previously, not only dwelling and practising at Dublin, but was Physician-General of the English Forces in Ireland."

THE LEPROSY DEBATE AT THE ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Two papers on Leprosy in Africa were read at the last meeting of the Royal Medical and Chirurgical Society. The discussion on them will be taken on Tuesday, the 10th, when it is expected that Dr. Hansen will be present and will join in the debate. It is hoped that this discussion may have important issues. The first of the

papers was by Mr. Tonkin, a surgeon who had traversed regions little known hitherto in the Soudan district of North Africa. In these, leprosy had been encountered as a very prevalent malady, and the paper consisted chiefly of a record of its author's personal observations respecting it. To these observations some valuable comments were appended.

The second paper was a report by Mr. Hutchinson as to the conclusions arrived at by him from a tour of investigation in Cape Colony and Natal.

It is of interest to note that the two papers, although written in absolute independence of each other, were at one in certain important points. Both, of course, recognised the rôle of Hansen's bacillus, and both agreed that the disease might be communicated from one person to another. Both were, however, of opinion that this possibility of transference did not cover the whole ground, and that it was impossible to regard leprosy as a disease spreading solely by contagion and without regard to other influences. Here, however, the authors parted company. Mr. Tonkin regarded an enfeebled state of the system, associated with a poor and for the most part vegetable diet, as the important predisponent which facilitated the attacks of the bacillus, whilst Mr. Hutchinson held that the parasite was introduced in one special article of food, namely, badly-cured salt fish. It is part of his argument that the disease in South Africa began near Cape Town, and was for long restricted to districts adjacent to fishing-stations. As roads were made it spread north and east along the lines of traffic. Quite recently it has passed over the Drakensberg range into Natal, being carried there by Kaffirs who had been into Cape Colony to work, and had there used salt fish as food. He believes that the communication of leprosy is always by the stomach and never by the lungs or skin, and that when it is transferred from one person to another it is by the contamination of articles of food. By far the larger number of cases are, however, *de novo*, and caused by bad fish.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON THE TREATMENT OF CASES OF INVETERATE RETROVERSION OF THE UTERUS.

[*Abstract.*]

BY J. BLAND-SUTTON, F.R.C.S.

MR. BLAND-SUTTON'S lecture was an argument in support of the thesis that the proper treatment in inveterate retroversion of the uterus is hysteropexy. This operation, he maintained, replaced the uterus in its natural position, and so far from preventing pregnancy it facilitated the development of that condition, which in itself is one of the most successful methods of overcoming chronic retroversion of the uterus. He admitted that there were cases of retroversion without symptoms, and explained that in these the distortion of the uterus was unaccompanied by any displacement of the ovaries. When, on the other hand, pain and other pelvic disturbances are present, these are evidences that one or both ovaries are dislocated from their normal position. In some cases the displacement of an enlarged ovary is the primary event, and the retroversion of the uterus is a consequence of this, whilst in other instances the ovary is dragged downwards by the abnormally situated uterus. Mr. Bland-Sutton also described the changes which may occur as a consequence of these displacements, pointing out more particularly how the softened uterus of a multipara may be altered in shape and may contract adhesions to neighbouring parts; and how, as a result of obstruction to the circulation, the ovary may become oedematous or its capsule be thickened from the contact of the uterus. He concluded by describing in detail the several steps of the operation of hysteropexy and by criticising the use of pessaries as a practice useless or even harmful.

A LUPOID FORM OF LICHEN SCROFULOSORUM.

(DAY'S LUPUS.)

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

GENTLEMEN,—The case with which we have to deal is in my experience unique. I therefore propose that we should, provisionally at least, designate it by the name of the gentleman to whom we are indebted for having the patient brought before us, and call it Day's Lupus. That it is a tubercular affection of the skin I cannot doubt, and inasmuch as it disorganises the skin of the affected parts and leaves scars, it must be allowed to belong to the lupus family. We are all well familiar with the conditions usually presented in what is called lichen scrofulosorum—how, in that affection, groups of dusky yellow-brown papules form, which groups shade off gradually into the sound skin without any abrupt boundaries. We know that these patches occur scattered over all parts of the body and limbs, avoiding, however, the face; and how, as a rule, they disappear after a few months' or years' duration, and leave no trace. Try to imagine a lichen scrofulosorum of which the papules should be red instead of brown, and wholly destitute of elevation, and which, instead of disappearing, should undergo steady aggravation, finally leaving the skin marbled with atrophic scars. If you do this you will have got a clear picture of our present case. It is not in the least like lupus vulgaris, for there is no thickening and not the slightest tendency to ulceration; and moreover, now, after eight years from the beginning, fresh patches are still making their appearance. It is much more like lupus erythematosus, but yet very different even from it, for there are no patches on the face and plenty on the limbs, and the patches show only lichenoid congestion with no trace of the scale-covered discs and rings which characterise that malady. Nor do the papules coalesce so as to leave continuous scars, but remain more or less separate, and leave a mottled pitting instead of

an extended scar. Nor is the disease the same with that which we now and then meet with as an infective angioma, for it certainly begins, not as merely vascular dilatation, like a superficial nævus, but as congestion located around hair follicles.

Dr. Day's patient is a young woman of 22, of fair complexion and rather delicate aspect. She has been considered delicate in youth, has been liable to a bad cough, and has on several occasions spat a little blood. She is, however, at the present time free from cough and in fair health. A maternal aunt died of phthisis, but both her parents and three sisters are all living and well. She believes that she has had measles three times, and once she had a severe attack of pneumonia. The history which she gives of her curious skin-disease is that at about the age of 14 she first observed a group of little spots on the inner side of her left thigh. These steadily increased, and the area of the patch extended. Gradually other patches made their appearance on the forearms and on the fronts of the axillæ, on the knees, and in the popliteal spaces. She now counts ten or a dozen patches, but in some places—as, for instance, on her neck—there are scattered spots concerning which it is doubtful whether they will come to anything important or not. No spots whatever have appeared on the face, and there are none on the trunk. There is a definite tendency to bilateral symmetry, but in every instance the patches come first, and attain their largest size on the right limbs. They are never in the least sore, but the epidermis over them becomes a little crinkly and exfoliates a little.

The eruption may, as I have already suggested, be considered as a sort of lichen-lupus, a self-infective, scar-leaving form of lichen scrofulosorum. I will endeavour to describe it in more detail.

It begins as minute spots of dusky redness, not in the least raised, and scarcely attended by thickening. These are formed around the orifices of hair follicles. The congestion which attends them can be removed by firm thumb-pressure, but it remains when they are examined under glass, however firm the pressure. These spots are arranged in ill-margined groups, near to the borders of which are many discrete spots, in which the changes are so slight that it is scarcely to be said that they depart from a normal condition. The early stages of the patches are very inconspicuous and difficult of identification, but the longer they last the more

conspicuous they become. The little lichen papules coalesce into irregular streaks and patches, and the intervening skin being pale, a marbled appearance is produced. At first I thought that the pale portions were scars, or lardaceous deposit, but after careful examination I became convinced that they represented healthy skin.

The patch on the inner side of the left thigh is the oldest, and shows the most advanced changes. It is as large as an outspread hand, and its margins shade off gradually, being bordered by discrete papules showing very slight changes. In the more central parts of the patch, however, the changes are very definite. The congested streaks are distinctly depressed, and in a state of atrophic scarring, reminding one of the florid scars often left after lupus erythematosus. The scar is, however, not smooth, but occurs everywhere as a series of little pits.

Such, then, are the facts as to this remarkable affection. We have no portrait of anything exactly like it in the Museum, although I have seen once or twice conditions more or less similar. You will observe that, like other forms of lupus, it keeps true to its assumed type, one patch being exactly like others. This is what we see in lupus vulgaris, lupus sebaceus, and lupus erythematosus. They do not as a rule run into each other, but each, however extensive or multiple it may become, keeps still its own special features. We observe the same law in all forms of cancer, and probably the explanation of the fact is the same in both cases. The infective germ-material which sets out on its travels from the parent patch is infective only to tissues of the same kind as those in which it originated, and in them produces like results. We may conjecture that in the present instance neither the corium nor the perivascular spaces, nor the sebaceous glands which open into the hair follicles, are primarily affected. The disease probably has its seat in the walls of the follicle itself, and is almost restricted to them. As regards treatment, I have suggested to Dr. Day that, in addition to the general measures suitable for a tuberculous subject, careful attention should be given to the destruction of the little papules by caustic. I would paint them all with minute dots of fuming nitric acid, or touch them with the needle-point of a cautery. I doubt whether my favourite mixture of tar and lead would be efficient, but as a milder measure it might be tried. Undiluted

carbolic acid might also be used. We must understand that the local destruction of infective centres is the thing to be aimed at, and, having regard to the large extent of surface involved, it is obvious that, both on the part of patient and practitioner, a large stock of perseverance will be requisite.



Elephantoid edema of one lower extremity in a girl. Lymph vesicles. Keloid of scar in bars. (Photographed from a patient sent to the Polyclinic by Dr. Fisher of Tiverton.)

ON A CASE OF ELEPHANTOID ŒDEMA OF ONE LOWER EXTREMITY,
ATTENDED BY LYMPHORRHŒA.

GENTLEMEN,—You will remember the case of elephantoid œdema of one lower extremity in a young child, which we had before us last week. I show you now a good photograph of it, which effectively brings out the great disproportion between the two limbs. The two long streaks running down the inner side of the thigh were not essential parts of the disease, but were broad parallel bars of keloid, in the scars of operation wounds. By the sides of the principal bars were several little nodules, which represented the scars left by the sutures. Our patient was a girl fourteen years old, and the history given was that the swelling had commenced in the leg six years ago, and that there had been no recognised cause for it. Since the beginning, the child had been liable every few weeks to attacks of slight illness, attended by much increase of swelling, and by the oozing of considerable quantities of a milky fluid from certain vesicles which are persistent on the upper part of the thigh. We could not trace any enlarged lymphatic trunks, nor were the inguinal glands materially enlarged. The increase in size involved all parts of the limb, including the toes, and on the latter the skin was becoming somewhat tuberculated.

I have preferred to use the expression “elephantoid œdema” rather than the name “elephantiasis,” and for a reason. We are too apt to connect with a definite name a substantive idea, and to imagine a disease which is complete in itself, and always due to the same cause. You will say, perhaps, But is it not so in this instance? Is not elephantiasis always due to lymphatic obstruction caused by the *filaria sanguinis hominis*? That is a theory concerning which I have much doubt. I do not think that we know the precise rôle which the *filaria* plays in the production of elephantoid œdema. For me, elephantiasis is merely a name for certain hypertrophic conditions, resulting from solid œdema, and more or less closely resembling the appearance of an elephant’s limb. Now, although these conditions are much more common in the tropics than in temperate climates, they occur in the latter with features just as definite as in the former. We have in the

Museum several good illustrations of English elephantiasis, showing conditions of hypertrophy which it would be difficult to surpass. Our present patient promises well to become one such should she live to adult life, and should treatment not be more successful in the future than it has been in the past. Yet I am not aware that the filaria has ever been identified in an English case. Our English cases have as a rule a history of recurring lymphatic inflammation rather than of mechanical lymphatic obstruction. An attack



Elephantoid hypertrophy of one lower extremity in an Englishman. (From a photograph taken for Mr. Hutchinson.)

resembling erysipelas is usually the initial event, and it is followed by others, each one leaving behind it its legacy of increased œdema. We see not a few cases in which the condition is threatened but is warded off by appropriate measures of treatment, those measures being support by elastic bandages and frequent resort to the recumbent position; and the use of steel, quinine, and purgatives. I show you a photograph of the legs of an adult man who was, I believe, so cured. Nor are our cases of English elephantiasis

confined to the lower extremities. We sometimes see the scrotum or the penis attacked, and there is a very interesting group of cases in which the face is affected, and which it needs some care to distinguish from myxœdema. Only the other day I saw a gentleman in good health, whose only ailment was solid œdema of the skin of the scrotum and perineum. He had experienced two attacks of swelling, each of which had confined him to bed for a time, and in the first of which the supposed exciting cause was excessive exercise in the saddle. He is certainly threatened with elephantiasis,

and the scrotum is a part which it is much more difficult to treat than the lower extremities.

Perhaps someone will suggest that these English cases are not "true" elephantiasis, and that the name should be restricted to the tropical and filaria-attended disease. Such a course would be arbitrary, and I doubt whether it would be advisable.

In proof that the same sequence of events is observed in countries where elephantiasis is endemic, I will quote a passage which I stumbled upon the other day when reading for another purpose. Writing of disease in Mauritius, Mr. W. Ford states: "In the Arabian elephantiasis, the first symptoms are those of general disturbance, swelling, with erysipelatous inflammation of some part of the upper or lower extremities—generally the latter—with fever, commonly called *l'érésipelle* in the colony. The first attack is curable, and may leave no trace behind; but similar ones recur from time to time with increased violence, and all the deeper-seated tissues become implicated."¹ To these recurring attacks, the term "Elephantoid fever" was well given by Sir Joseph Fayrer.

Thus you will see that recurring attacks of what looks like a mild erysipelas, are part of the disease as witnessed in the tropics, just as in England. It would be an enquiry of great interest to determine what these attacks really are, and whether they have any actual connection with Fehleisen's micrococci. That the lymph-spaces and sometimes the lymph-trunks are involved seems well established, and I see no reason for hastily rejecting the suggestion that this organism may be capable of existing in permanent symbiosis in the tissues, with recurring periods of activity.

¹ See College of Physicians Report on Leprosy, page 83.

The development of lymph vesicles in the skin of the thigh, from which during the recurring attacks of inflammation there is a discharge of fluid, is a very rare epiphenomenon in our present case. I well recollect, many years ago, seeing at one of our Societies a case, brought, I think, by Mr. Sydney Jones, in which it existed. The case was very like that of our own patient.

As regards the connection of the disease with the filaria, you will find a chapter brimful of interesting facts in Manson's "Tropical Medicine." I shall, however, be astonished if, after reading it, you do not come to the same conclusion that I have done, namely, that a great many of the most pronounced forms of elephantoid hypertrophy of limbs have, in the tropics as in England, no connection whatever with the parasite. It is probably different with the lymph scrotum and the lymph varix, but it is to the examples of huge hypertrophy that the term elephantiasis, if used at all, should be applied. The causes of these are probably the same in the tropics and in England.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY WM. EWART, M.D., F.R.C.P.

Tuesday, May 20.

Koch's Tuberculin in the Diagnosis of Phthisis Pulmonalis.

DR. EWART discussed the use of tuberculin as a diagnostic agent in connection with the case of a young woman who, a year ago, had an attack of right-sided pleurisy with more or less bronchitis, and who since this illness had lost flesh and strength. He pointed out that the majority of cases of spontaneous pleurisy are of bacillary origin, though he was not prepared to admit that this was true of every case. But in the instance under consideration it had to be noted that the evidences of pleurisy had not entirely disappeared, and though there was no pyrexia and no distinctive signs of phthisis pulmonalis, the patient's health and general condition were anything but satisfactory. In these circumstances it was, Dr. Ewart argued, advisable to endeavour definitely to settle the diagnosis either one way or the other. And he proposed to do this by means of tuberculin. A dose of one milligramme would be subcutaneously injected, and failing the production of pyrexia and other evidences of reaction the dose would be cautiously and gradually increased to five or even ten milligrammes. If during the practice of this method a reaction developed, this would be a distinct demonstration of the presence of tubercle, whilst the absence of reaction would be strong presumptive evidence of the non-existence of tubercle. The negative conclusion, however, would not be quite absolute, as in exceptional

instances the injection of tuberculin is not followed by a reaction even in the presence of tubercle.

Bronchiectasis in a Child.

A child of six years was brought by Dr. Wylie with the history of cough and abundant yellow expectoration, these symptoms having been present in greater or less measure since the patient was nine months old. The physical signs were those of chronic bronchitis and bronchiectasis, and Dr. Ewart discussed the structural changes produced in the respiratory passages by long-continued muco-purulent catarrh. He insisted on the importance in the scheme of treatment of securing the removal from the bronchial passages of the excessive secretion, and though in the present case the long persistence of the disease made a satisfactory issue improbable, he considered some benefit might be expected if the indication just defined could be attained. For this purpose he advised that the cot in which the child slept should be raised at the foot in order to secure the advantage of gravitation in facilitating the expectoration of the bronchial mucus and pus. He also prescribed the use of a respiratory jacket consisting of a light canvas material having "let in" on each side a piece of elastic tissue. The pressure of the elastic favours expiration, and thus indirectly promotes inspiratory activity; it also increases the expulsive power of the cough. Had these measures been adopted earlier in the case, Dr. Ewart would have anticipated a very successful result.

At a previous demonstration, Dr. Ewart examined the following cases :—

(1) *A case of swelling of the wrist* was considered to be, as suggested by Captain Hayward Pinch, most probably of the nature of a diffuse ganglion, and to require surgical rather than medical treatment.

(2) *A case of partial loss of memory* after a fit of unconsciousness in a young woman. The patient was not apparently hysterical, and presented no trace of hemiplegia or aphasia. In the absence of any evidence of syphilis, the existence of arterial degeneracy at so early an age was improbable. The possibility of a minute embolism was not altogether excluded, in spite of the absence of any cardiac

murmur. Again, the seizure might have been epileptic, although the patient had not previously suffered from fits. Whilst the etiology remained doubtful, Dr. Ewart was inclined to regard the condition as one of functional debility, and recommended a course of valerianate of zinc, which might also prove of service in checking any epileptic tendency, if it existed.

SURGICAL CASES.

BY JAMES BERRY, F.R.C.S.

Wednesday, April 30.

THE following cases were shown :—

- (1) A boy upon whom excision of the astragalus had been performed five years previously for extreme talipes varus.
- (2) A case of infratrochanteric osteotomy for ankylosis after hip disease.
- (3) A young woman with a painful renal swelling.
- (4) An elderly woman with a large and probably malignant tumour of the thyroid gland.
- (5) A man with a simple stricture of the œsophagus, due to swallowing a corrosive poison.
- (6) A man with an epithelioma of the œsophagus, and wearing an œsophageal tube.

BY JONATHAN HUTCHINSON, JUNIOR, F.R.C.S.

Wednesday, May 7, 1902.

Case of Chronic Lymphangitis of Arm (? Tubercular).

THE patient, an adult male, complained of a painful swelling in the left armpit. This had been present about two months. It was the only symptom from which the patient suffered, and previous to its development he had enjoyed unbroken health. On

examination there was found a considerable swelling about the middle of the left axilla; it was adherent to the skin, was tender, and suggested the possible presence of pus. It seemed probable that the swelling originated in a lymphatic gland, and that it was going on to abscess formation. There was, however, no history or evidence of a scratch or sore on the hand or forearm through which septic absorption might have occurred. On this point it must be remembered that a very slight peripheral lesion may give the opportunity for such absorption, and that occasionally a long interval elapses before evidences of secondary lymphatic irritation appear. Hence the recollection and signs of the primary wound may readily have disappeared. A further fact in the case was the presence of an indurated cord which could be traced from the swelling in the axilla downwards along the inner side of the arm, close to the brachial artery, as far as the elbow. There can be no doubt that this was a thickened lymphatic trunk. It was not particularly tender, and there was neither anæsthesia nor tingling in the area of distribution of the internal cutaneous nerve, so that the suggestion of a swollen nerve trunk could be put out of court. A review of the entire facts thus showed a chronic inflammatory condition of lymphatic trunks in the upper arm and of one or more lymphatic glands in the axilla. In the absence of all evidence of any opportunity for septic absorption through a breach of surface on the distal portion of the limb, it was not unreasonable to suggest tubercle as the most likely explanation. The treatment suggested was of the expectant order. Rest for the limb, with the local use of oleate of mercury and morphine, were prescribed, and in addition a generous diet and favourable hygienic conditions. The necessity for operative interference must, however, be regarded as more than a possibility.

Operative Treatment of Ununited or Badly United Fractures.

(1) In this case the patient, a man of 40 years, sustained a fracture of the humerus about the middle of the bone some four months ago, the injury being the result of direct violence. Though adequate treatment had been well and thoroughly carried out from the date of the injury, union had not occurred. There was nothing

in the patient's antecedents or general condition which could be recognised as explaining this defect. Possibly, as the line of fracture was just below the insertion of the coraco-brachialis muscle, the non-union might, in harmony with the late Mr. Curling's theory, be due to injury to the nutrient artery of the humerus.

Examination revealed the existence of a typical false joint at the seat of fracture, and a skiagraph showed that there was a considerable outgrowth of bone from the end of the lower fragment, forming a socket for the reception of the upper fragment.

Mr. Hutchinson strongly advised operation as the appropriate treatment. Without such a measure union is now extremely improbable, and if left in its present condition the arm will remain almost useless.

[Since the above demonstration the patient has consented to operation. By an incision on the outer side of the arm the musculo-spiral nerve was carefully exposed and drawn aside, the ends of the bone were then cut obliquely and were fixed in contact with one another by two loops of silver wire passed through apertures made by the drill—in short, the ends of the fractured bone were spliced together by silver wire.]

(2) This patient, a man of 30 years, sustained a fracture of the right radius two months ago. The fracture was the result of direct violence, and was situated one inch below the insertion of the pronator radii teres. He now complained of imperfect power in his right hand, and it was evident that the ability to supinate his forearm was much limited. This unfortunate result was certainly not due to too prolonged an application of the splints, as these had only been worn some three weeks, and there was no stiffness in the movements of the fingers. The responsibility is rather to be attached to the fact that the forearm was put up in the fully pronated position; union has therefore occurred in this position, the lower fragment being fully pronated, and the upper one supinated by the biceps and supinator brevis muscles. This has meant an unfortunate position, limitation of movement, and prejudice to the accurate co-ordination of the muscles of the hand and fingers. Mr. Hutchinson advised osteotomy and the re-setting of the bone in the fully supinated position. He emphasised the necessity of selecting this position in all fractures of the radius except those involving the lower end of

the bone—a rule originally defined by Sir Astley Cooper. [The operation advised has since been performed. Union was found to be firm. The bone was chiselled through, and the forearm supinated and put up in this position.]

DISEASES OF THE EYE.

BY R. MARCUS GUNN, F.R.C.S.

Friday, May 9, 1902.

Some Syphilitic Affections of the Eye.

A BOY of 16 years was shown as an example of interstitial keratitis. The left eye had been affected but had now completely recovered, and this was described as a common issue of the condition. On the other hand, the right eye had recently become involved, and the boy was suffering from severe photophobia, and presented a diffuse opacity of the cornea with a considerable amount of ciliary injection. The diagnosis was entirely beyond dispute, as in addition to the interstitial keratitis, the upper central incisor teeth were notched in characteristic fashion. Mr. Gunn emphasised the favourable character of the prognosis in these cases. When both eyes are affected the condition is of course a very distressing one, and more particularly when it occurs towards adult life and the occupation of the patient is necessarily suspended. The patient, for all practical purposes, is blind, and also suffers from photophobia and more or less lacrymation. These circumstances necessarily cause him much distress, and lead him to take a very gloomy view of the future of his eyesight. Nevertheless he can be assured confidently that he will regain good vision. The length of time which will elapse before this is attained varies in different cases. It may be as long as twelve or eighteen months, but sooner or later the cornea will become clear, and the power of sight restored. The exceptions to this rule are mere clinical rarities. Only very infrequently indeed does interstitial keratitis lead to abscess and ulcer of the cornea, with the result of a grave permanent corneal opacity. The

most frequent date for the occurrence of interstitial keratitis is during the period of the second dentition. Exceptions, however, occur in both directions. Thus it may be seen in early childhood, and as a rare event its appearance is delayed until about the age of thirty. In young children the centre of the cornea is commonly first affected, whereas in older patients the affection commences as a salmon-coloured patch at some part of the periphery, and then gradually involves the entire area of the cornea. The younger patients usually have both eyes affected at or about the same time, while, when the affection appears later in life, a considerable interval may elapse—even several years—before the second eye is attacked. As a very unusual event, interstitial keratitis occurs as a consequence of acquired syphilis.

In addition to the cornea the effects of inherited syphilis may be seen in other tissues of the eyeball, more particularly in the iris and choroid. Choroiditis usually appears during the second or third year of life. It is seen in the form of small patches of exudation widely scattered over the fundus, and affecting both the macular and peripheral regions. Subsequently, that is after absorption of the exudation, atrophy of the choroid occurs at the affected areas, and thus the ophthalmoscope shows small white spots and patches, each of which is surrounded by a zone of black pigment (disseminated choroidal atrophy). This condition suggests very strongly the diagnosis of inherited syphilis.

When iritis occurs as a result of inherited specific disease it is usually a very early event, appearing generally either during intra-uterine life or in early infancy. In the former it may produce a film covering more or less completely the opening of the pupil. Uncomplicated iritis from inherited specific disease is a rare event, even in very young children, and in older patients it is almost invariably associated with interstitial keratitis.

Both choroiditis and iritis may result from acquired syphilis. Choroiditis is not very common, and is relatively more frequent when infection occurs later in life, than when the disease is acquired in early adult life. The patches of exudation with subsequent choroidal atrophy are fewer in number and larger in size than those due to inherited syphilis, and with them are found opacities in the vitreous. Specific iritis, on the other hand, is by no means an

uncommon affection in young adults. The iris has a dull, discoloured appearance, there is injection of the ciliary region, and the pupil is contracted. The degree of pain varies within very wide limits. Sometimes it is severe, while at other times it is hardly the subject of complaint. Not infrequently there is a definite area of exudation (gumma) in the substance of the iris not far from the margin of the pupil. A similar appearance may be caused by a tubercle affecting the iris. But tubercle of the iris is very uncommon, and it occurs in children rather than in young adults. The fact that there is a gumma of the iris does not necessarily mean that the case is a severe one. Under mercury, absorption takes place, and nothing more serious results than a small scar in the iris substance. A similar remark may be made in reference to an exudation occluding more or less the pupil. Atropine to keep the pupil dilated, and hot fomentations to hasten the processes of repair, form the local treatment, whilst mercury, of course, is administered internally. When there is much photophobia smoked glasses should be worn. The ordinary eye-shade is not of much value, more particularly when it is limited to the affected eye only.

A Case of Phlyctenular Ophthalmia.

The patient was a young woman, and she was presented as a clinical contrast to a case of interstitial keratitis. It was pointed out that both affections are often met with in young adults, that both produce photophobia, and that in each there is more or less opacity of the cornea. The differential diagnosis was also discussed. During the acute stage it is seen that the corneal opacity in phlyctenular keratitis is associated with a condition of ulceration involving a loss of substance, whilst in interstitial keratitis the surface of the cornea is smooth and unbroken. The course of interstitial keratitis is for some time one of increasing severity, followed by gradual improvement to practically complete and permanent restoration of the normal corneal transparency. Phlyctenular keratitis, on the other hand, may soon improve under appropriate treatment, but there is left at the affected area a distinct and permanent opacity, and the affection almost invariably recurs again and again. The disease is often found in patients having a tuber-

cular family history, and there may develop in the patient, sooner or later, evidences of pulmonary phthisis or other manifestation of tubercle. As opposed to this, interstitial keratitis is often accompanied by notched upper central incisors, deafness, depression of the bridge of the nose, scars at the angles of the mouth, or other evidence of syphilitic taint. The prognosis, so far as the condition of the cornea and the resulting effect of this on the sight are concerned, is much more anxious in phlyctenular keratitis than it is in interstitial keratitis. The former, with its marked tendency to ulceration, is extremely likely to be followed by an opacity which may readily be situated so as to seriously interfere with direct vision.

DISEASES OF THE THROAT AND EAR.

BY HERBERT TILLEY, M.D., F.R.C.S.

Friday, May 16, 1902.

Acute Suppuration in the Mastoid Antrum.

THE patient, a middle-aged man, had complained during six weeks or so of pain in the right ear, accompanied by a discharge from the external meatus. During the few days immediately preceding the date on which he first came under observation, the discharge had almost or entirely ceased. The pain, on the other hand, had become more severe, and had extended widely over the right side of the head. Examination revealed a small perforation in the upper posterior quadrant of the tympanic membrane, and in the mastoid region there was considerable swelling and tenderness, with redness and œdema of the skin. Dr. Tilley explained these facts as symptoms of acute suppuration of the antrum, and described the operation necessary to evacuate pus from that cavity.

Cases of Chronic Otorrhœa.

One of the patients was a boy, in whom, in spite of the removal of adenoids, discharge from the ear persisted. Various forms of

local treatment had been in vain, and it was explained that such a state of matters, especially when associated with the formation of polypi or granulations in the tympanic cavity, should give rise to the suspicion of caries of the ossicles, or more deeply-placed mischief in the mastoid antrum or cells. Examination of the present patient had detected a carious condition of the ossicles, and these had been removed with satisfactory results. In a second case, the same procedure had not been successful in stopping the discharge, and it had therefore been necessary to perform the radical mastoid operation. In the first of the two cases here described, the patient had been provided with an artificial drum, and Dr. Tilley demonstrated the method of making this, and the manner of its application.

DISEASES OF THE SKIN.

BY J. M. H. MACLEOD, M.D., M.R.C.P.

Monday, April 7, 1902.

The following cases were demonstrated :—

A Case of Alopecia following Ringworm.

THE patient, a little girl, aged 3 years, had been under treatment for widely-disseminated small-spored ringworm of the scalp during the last eighteen months, at Paddington-Green Children's Hospital. The treatment adopted consisted chiefly of rubbing in an ointment containing equal parts of carbolic acid, ointment of nitrate of mercury, and sulphur ointment. This had resulted in a thorough cure of the ringworm, but had left the affected area completely bald. The hair was gradually beginning to grow again, and doubtless the alopecia will soon disappear. The condition was not that of true alopecia areata, in that neither the typical clavate stumps nor the characteristic plugged follicles of the latter disease could be detected; it was simply a baldness resulting from the vigorous treatment. Such cases are of special interest, since it has been asserted

that alopecia areata is frequently, if not invariably, preceded by ring-worm.

A case of Lichen Urticarus or Strophulus.

The patient was an infant, aged 12 months. The case was brought forward to illustrate one of the most prevalent skin-diseases of infancy. The arms, legs, and trunk were at the time of exhibition covered with the red blotches in the centre of which an urticarial wheal might be detected, and with the small excoriated papules which characterise the disease. The question of the differential diagnosis, and the possibility of confusing the vesico-bullous variety of the disease with varicella, were discussed.

CASES WITH COMMENTS FROM THE SURGICAL
CLINIC.

BY MR. HUTCHINSON.

Case of Multiple Lupus Vulgaris ("Psoriasis Lupus").

(Dr. Guthrie Rankin's Case.)

WE have before us, Gentlemen, the best example which you will ever see of what I once called "psoriasis-lupus." The little boy has numerous dry scaling patches on his limbs, face and trunk, and they are arranged with almost exact bilateral symmetry. They are as abundant as are those of an ordinary case of psoriasis, and are distributed not unlike that disease. The disease is, however, lupus vulgaris and it may be doubted whether it has any real relationship to psoriasis. The resemblance is probably only accidental. About this, however, one cannot feel quite certain. The term was designed to denote a hybrid, and if there be no real hybridity, it had better be forgotten. There is of course no reason why a child inheriting a tendency to tuberculosis should not inherit also a skin liable to psoriasis, and why, under such conditions, a mixed form of eruption should not be produced. We have, however, a strong

suspicion that in lupus vulgaris all the patches, however many there may be, are the results of local inoculation, and that in psoriasis they originate from within. In this, however, we may be mistaken. There is no difficulty in establishing a most definite distinction between the processes of psoriasis and those of lupus. In this latter the deep layers of the skin are involved, and the result is disorganisation and scar, whereas in psoriasis when under treatment the patch disappears, and the skin is left perfectly sound. In this instance the process is most definitely that of lupus, and scars are to be seen in several places, especially on the face.

We are indebted to Dr. Guthrie Rankin for the opportunity of seeing the boy, who is under his care in the Royal Hospital for Children. Dr. J. F. Northcott, the resident medical officer, has kindly sent with the boy a few particulars as to his family. It appears that his parents are in good health, but there is phthisis on the mother's side. The boy is their eldest, and had a clear skin and good health until two years ago, when he had measles, after which this condition followed. The patches, we are told, are spreading. We have no definite information as to the earliest stage, but I have no doubt that they all appeared within a comparatively short period—say within six months. Such is the invariable history in multiple lupus vulgaris. The patches multiply during the course of a few months, apparently by contagion from one to another. You will easily understand how the delicate skin of a young child and habitual scratching might lend themselves to such transferences. After a short period the tendency to increase in number ceases altogether, and very possibly some of the patches may disappear, leaving sound scars. Those which remain, however, will continue, unless treated, to increase in area through the whole of the patient's life. It may be conjectured that in the early stage the tubercular virus, which is the essential cause of lupus, is mixed with the staphylococcus pyogenes, which gives virulence to its contagious properties, and that after a while the one partner dies out of the firm and leaves its longer-lived associate to carry on the business on somewhat different lines.

It is of interest to note certain minor differences in the patches on different parts of the body. In most we have the dull brown, slightly scaly patches which are sometimes called *Lupus exfoliatus*. In some of these the "apple-jelly" growth can be recognised. On the fingers

however, the conditions are very different, the patches being rough, cracked, and papillary, like "Lupus necrogenicus." We can foretell the course of the disease in future, for we happen to possess a series of valuable portraits illustrating various stages in another and almost exactly similar case. The patches will steadily increase in size. We have, in the knowledge of this fact, a powerful incentive to early and energetic treatment. We will not suggest the light treatment, for the eruption is so abundant that it would take the whole of the rest of the boy's life to carry it out. My plan would be my usual one—the free use of the actual cautery. Under an anæsthetic a dozen or twenty of the patches might be thoroughly destroyed at one sitting, without risk of any serious constitutional disturbance, and two or three repetitions of the process might perhaps complete the cure. Meanwhile the boy should be well fed and kept very warm.

Blue Patches and Streaks on the Feet of Girls. Question of Deception.

You will remember a girl who was brought to us some weeks ago with blue patches and streaks on her feet. We had a drawing taken of them. We suspected artificial staining. Since her first attendance my attention has been called by two of our members, Sir William Kynsey and Dr. Conner, to a record of similar cases which have recently come under the notice of the Bristol profession. Concerning them I will read a brief report which has appeared in the *Bristol Medico-Chirurgical Journal* for March of the current year.

"At a meeting of the Bristol Medico-Chirurgical Society on December 11, 1901, Dr. G. Parker showed a case of chromidrosis. Dr. Stack said they must have admitted six or seven cases, like the one shown, in recent years. The blue discolouration had only been between the toes, and had disappeared after maintaining cleanliness for a time. Dr. Parker replied that he had tried to remove the blue stains between the toes in this case with chloroform, ether, soap, paraffin and other things, but failed. Wearing white socks had not changed it."

Our experience was much like that which Dr. Parker records. We could not remove the blue stain by anything which we washed it with. It was evidently in and not on the cuticle. Nevertheless I do not abandon the belief that it was produced intentionally by the girl. What dye she used I do not know, but I feel no doubt that

the stains she has repeatedly shown us are caused by a dye. Mr. Hitchins has taken much trouble in the attempt to find out what she uses, and with certain aniline dyes he has produced on his own skin stains very like those which she shows us. It is exceedingly difficult in these cases of suspected trickery to make the thing quite certain. I can only aver that these blue streaks are like nothing I ever saw as the result of *bonâ-fide* disease. They were too blue, too streaky, and too abrupt in outline. You will remember that the girl told us that she had had a similar attack two years ago, and that then a sister had them also. This in itself was a suspicious statement. We have now seen the girl three times, at intervals of two or three weeks. The patches have changed their places and have entirely left those first affected. To-day they are few in number and present only between the toes. I am a very feeble believer in "Chromidrosis," for nearly all the cases so named have been proved to be artificial. In the present case it is staining of the skin itself that we have to deal with; there is no question of coloured perspiration. You will ask what motive the girl has for painting her toes. Well, to amuse herself at our expense. To excite curiosity in others, and become an object of attention, is a motive quite sufficient, with some girls, for any kind of vagary. I have placed under the microscope on the table some short stumps of hairs. They are absolutely normal, and no one can entertain any doubt that at both ends they have been cut. They were brought to me this morning by a lady from Devonshire, who brought also her daughter, a pretty girl of 14, who was "losing her hair." Long tresses were brought for my inspection as well as these stumps. They were said to have fallen, but the ends of all the hairs were certainly cut. The eyelashes were reported also to be falling, but on looking at them it was as obvious as possible that the scissors had been used. Now, this girl had a comfortable home and most indulgent parents, and no reason whatever could be assigned for her playing tricks. Having formerly had a fine head of hair, she had reduced herself to the condition of a close-cropped inmate of a prison. Her only reward had been repeated consultations with doctors and finally a journey to London. I have several exactly similar cases, and they always occur in those whom their relatives think most unlikely to do such things. I have always great difficulty in convincing their friends.

*Diffuse Morphœa (Scleriosis Cutis) with Raynaud's Phenomena
and peculiar induration of the skin.*

(Dr. Waldo's Case.)

Mrs. V., aged 58, married at 40, had a miscarriage but no live births. Mother died at 84; a brother died of consumption. She has had shingles and phlebitis. She is of dark complexion. Every winter in early life she used to lose her voice. When a girl she had blood-spitting and was considered consumptive.

Her hands began to be affected 20 years ago by gatherings under her nails. Her finger ends used to die and become white. For six or seven years she was almost well. It is ten or eleven years since her face began to show spots.

Her face is now covered with stigmata, but the skin is not very tight; it is thin and atrophic, but the face is fairly plump. The stigmata are of a dusky claret tint, and cover almost the whole face—nose, cheeks, and forehead. They extend also upon her neck and upper part of chest. Her neck is brown and freckled.

The ends of the fingers are hard and wooden, but this condition does not extend higher than the second joint, and the skin of the back of the hand is supple and normal. The palms are dry and glazy but show no corns.

The most peculiar feature of the case is the presence of indurated plaques in the deep layers of the skin over the backs of forearms. The largest is on the right forearm; that on the left is only just beginning. That on the right she thinks has been present 5 years. There is another induration a little above the wrist. It is more definitely subcutaneous and of more recent origin. The upper patch involves the skin, and at three separate spots there is threatening of an indolent pustule—the skin looking yellow over the top.

The hands ache with cold.

Cancer of the Testis in Early Life. Transmutation in Hereditary Transmission.

Our patient in this case is a man of 32, who in the course of his occupation as a farmer often rides young horses. On one of these occasions, a few months ago, he was conscious of having bruised his testicles. His paternal grandmother died, aged 80, of cancer

of the breast, of only about two years' duration. His father, who comes with him, is healthy.

He first noticed swelling of the right testicle about two months ago.

He has lost flesh during the last month, and he has some pain in the back, chiefly in the right loin. Lumps can be felt in the abdomen, extending up from the external abdominal ring. You see that the affected testis is as large as a fist, and is fixed firmly to the inguinal ring by thickening of the cord. The scrotum is dusky, but the skin does not adhere to the gland. There is a deceptive sense of fluctuation in the tumour, and it has indeed been punctured in the belief that it contained fluid. We are told that nothing was obtained, not even blood.

There can, I fear, be no doubt as to the diagnosis. The rapid growth, its even roundness, the concealment of all anatomical distinctions, the involvement of the structures of the cord, and lastly the intra-abdominal growths, combine to denote its malignancy. It is too late to operate, for it would be necessary to follow the disease into the abdomen, and after a dangerous operation little or nothing would be gained, for the disease would be almost certain to return quickly. It may indeed be confessed that operations for malignant disease of the testis are even in early stages very unhopeful. I do not know that I can remember a case of my own in which recurrence did not take place. I have, however, repeatedly known several years to elapse. In two cases I have known the other testis to be attacked, an occurrence which would appear to denote either strong constitutional proclivity or remarkable tendency to blood diffusion. It is inexplicable on any suggestion of lymphatic conveyance of germs, which in so many other forms of recurrence of cancer is the true explanation. Fitting with the theory of strong constitutional predisposition, we have the facts that cancer of the testis often occurs at a comparatively early age and with a family history of the disease. Very often the family history illustrates what we call transmutation in transmission—a very important law in respect to inherited cancer. In this instance we have a grandmother dying in old age of scirrhus of the breast, and her grandson, at the age of 32, developing a soft, rapidly-growing sarcoma of the testis.

*An Example of an Exceptional Form of Lupus in an Early Stage
and in a Young Subject.* *The Bath case*

The conditions in the boy whose portrait I show you were very peculiar, whether taken alone or in connection with their history. I saw him first on June 9, 1901. He was a well-grown boy of intelligent aspect, eight years of age. His cheeks and chin were covered with florid spots, some of them discrete, but others confluent into irregularly-margined areas of considerable size. None of them were circular, nor did they show evidences of spreading at their edges. I was told that although they varied as to colour and conspicuousness at different periods, they were for the most part stationary. They had been present for three years at least, and were only very slowly increasing. They had caused no inconvenience, and had as yet received but little attention. It was chiefly because the boy had been annoyed by the remarks of his schoolfellows that he was brought to me. The central parts of the cheeks were the parts chiefly affected, but there were many small spots on the chin and a few less distinct ones on the bridge of the nose. There was no trace of a vesicle or pustule or comedone. The condition was one of vivid erythema, with a certain very slight amount of thickening of the part affected, but without any tendency to excoriation or exfoliation of the epidermis. I was told that it had been thought that certain articles of food made the eruption worse, and that exposure to the air and especially exercise had the same effect. Probably, however, this was only the result of increase of the general vascularity of the parts. Although I was assured that the boy had nothing amiss with his skin on other parts, I asked to have him undressed. I then found over the lower part of his back a number of conspicuous scars, some of them with a certain amount of deep induration and others quite superficial. There was also a group of slightly-marked erythematous stains, not wholly unlike those on his face, but far less conspicuous. These scars, I was told, had followed sloughing abscesses from hypodermic injections of brandy, administered during a condition of extreme emergency soon after his birth.

In attempting to form an opinion as to the nature of the skin affection in this case, I was obliged to reject the suggestion of any

form of acne, on account of the youth of the patient and the entire absence of any tendency to pustulation. It was not any ordinary form of lupus. From lupus vulgaris it was distinguished by the multiplicity of the spots and the symmetry of their arrangement, and by the fact that the eruption was almost purely erythematous. Its arrangement might be supposed to fit tolerably well with lupus erythematosus, but then there were no discs, not a trace of exfoliation or even of roughness, and a great number of the spots were not bigger than pins' heads. The three years' persistence of the eruption, with very slow but steady progress and no temporary disappearance, made me feel tolerably confident that it must be assigned to the lupus family, and that its future course would be one of chronic persistence. In asking as to facts in reference to hereditary tendency to tuberculosis, I could get none excepting the curious one that the boy's maternal grandmother had suffered from lupus vulgaris on the tip of her nose. It had, however, been but a slight affair, and had been cured by local treatment, leaving a scar. The boy himself looked rather delicate, and I was told that he had had three attacks of pneumonia, but no indications of phthisis. We arranged to have a portrait done by Miss Green, and to examine the boy again on another occasion. In the meantime he was to take quinine. The case struck me as possibly one of lupus, modified by the youth of the patient.

The beginning of the eruption was in red spots on each side of the bridge of the nose, "as if he had been wearing spectacles."

The "Falling Sickness," Epileptiform Attacks, possibly of Syphilitic Origin.

This patient, a clerk, age 47, gives us the history of somewhat peculiar seizures, no doubt of an epileptiform character. He says that he is liable to fall from his chair, or to fall in the street when walking, without loss of consciousness and without convulsion. He gets up again directly, and feels no worse. He has frequently fallen from his stool in his office, to the great disturbance of his fellow clerks. Although the attacks are very brief, he not unfrequently passes urine during them. He never bites his tongue, and, so far as he knows, he is never in the least convulsed. A feeling

of numbness in his hands, most often in the right, usually precedes his falls. He has been sent to me because it has been thought that the attacks may be due to syphilis. On that point, the facts are these. He had syphilis twenty-seven years ago, and he now has scars on his legs, with thickening of the tibiæ from old periostitis. He complains of pain in the back of the head and vertex, which is worse at night, though never very violent. Although there is nothing to warrant a positive diagnosis, I certainly think that we shall be on the safe side to treat him with specifics.

Cancer of Both Breasts: Question of Operation.

I make no doubt in this case that there is a scirrhus growth in each breast. The breasts are rather large, and in the middle of each is a hard mass. It is much larger in the left, in which it was first noticed, and on this side the glands in the armpit are enlarged. Does the occurrence of cancer in both breasts in any way forbid operation? I certainly think not. I have repeatedly removed both in cases in which the second was affected some time after the first had been removed, and with excellent results. One patient is living, and quite well, fifteen years after the first operation and twelve after the second, and another six years after the second. In more than one instance I have removed both breasts at the same sitting, and with very good results, so far as I know, but I am not able to trace the patients. In this instance I should advise removal of both at the same time. The occurrence of cancer in both breasts does not imply infection from one to the other, nor perhaps any very strong constitutional tendency to cancers. It means only that two portions of the patient's body alike in structure and function have become predisposed by senile changes to cancerous growths. The disease may still be strictly local, and the risk of recurrence may be no greater than if the disease were single.

Scirrhus of Base of Nipple (Dr. Gabe's Case).

This patient shows us a very unusual form of scirrhus of the nipple. A little, very hard disc involves the lower half of the areola and pulls down the nipple. It is slightly ulcerated, but unlike that which occurs in the condition known as Paget's nipple

cancer, it has shown no tendency to spread on the skin. It might be taken for an indurated chancre, and some very hard and movable glands below the axilla might be thought to confirm that diagnosis, but the dates put it quite out of question. It has been present four years. There is no evidence of any growth in the breast itself, and, as you see, I can take hold of the nipple and lift it away from the gland. It has not become fixed. Although, however, the gland itself seems free, I should recommend excision of the whole. It is not only a more efficient operation, but I might almost say that it is a simpler one than excision of the nipple only.

NOTICE.

A MEETING of the Standing Committee on *Leprosy* will be held at 5.30 on Thursday, June 12, when it is hoped that Dr. Hansen of Bergen, will be present. The consultation on this day will be in part devoted to Leprosy.

CORRESPONDENCE AND ANSWERS.

INSUSCEPTIBILITY TO VACCINATION.

To the Editor of the POLYCLINIC.

"DEAR SIR,

"Some time since I wrote to you, telling you that I had been vaccinated sixteen times, and that my arm had never taken. You kindly answered my letter, and advised me to be vaccinated from a healthy infant (arm to arm) at seven days. I have taken your advice, and the medical man who vaccinated me was most painstaking and careful, but I am sorry to say my arm has not 'taken.' I thought you would be interested in the result, from a professional point of view."

* * *

"17, Stonegate, York.

"May 17, 1902.

"DEAR MR. EDITOR,

"I notice an article in the POLYCLINIC on arsenic and cancer. Do you realise that practically all wall papers contain arsenic in quantity? Two or three years ago I was fitting up a 'den' for myself and tested the proposed papers for arsenic. They *all*, even those warranted free, contained it. In the end I had the room colour-washed instead of papered.

"Yours truly,

"TEMPEST ANDERSON, M.D."

* * *

SYMPTOMS AND SIGNS.—F.R.C.P. draws our attention to the following extract from a Clinical Lecture by Mr. T. in one of our contemporaries:—"Now, I like to

distinguish between symptoms and signs. The symptoms are those which the patient complains of, the signs are those which you see for yourself."

Mr. T. is to be praised for his wish to draw a distinction between objective and subjective symptoms, but he ought not to confuse his pupils by calling the subjective class "signs." Both may become signs when their meaning is understood, and neither is so so long as it is otherwise. A sign is a symptom which is recognised as pointing definitely towards a certain conclusion. All the phenomena of an illness are "symptoms," but many of them may not rise to the dignity of "signs." There is the same difference that there is between posts and signposts. There may be two or three posts at a corner of a road, but none of them are signposts unless so superscribed as to indicate the direction to be taken. Symptoms concerning which we can have only the patient's statement are "subjective," those which the surgeon can inspect for himself are "objective."

* * *

COMMENSAL COMMUNICATION OF LEPROSY.—Amongst people who chew tobacco and eat opium it is very possible that the bacillus may be introduced by a gift from a leper's hand. Captain Fortesque reported, concerning Kaon Island, a leper home in Guiana, that "much trouble had been caused by the persistent way in which the lepers give tobacco and opium to the working parties of convicts employed on the island."

* * *

DR. B. enquires as to facts respecting the experimental inoculation of leprosy.

A Norwegian physician inoculated himself and twenty others with leprosy material without result. Profeta, in Italy, between '68 and '84 inoculated two women and eight men without result. Many have inoculated animals without result. (See Leloir and Arning.)

* * *

MEDIAEVAL LEPER HOUSES.—The following letter from the pen of the late William Square (the elder), of Plymouth, has been placed at our disposal by a member. It is of much interest as illustrating the real nature of the mediæval leper houses. They were not places for compulsory segregation, but of privileged retreat. The lepers were to elect each other. It also gives the date of the last leper in Cornwall—the county in which leprosy lingered longest in the British Isles:—"Staying at the White Hart, Launceston, on the way home from seeing a patient, I found an old copy of 'Gilbert's History of Cornwall,' published 1820. After a description of Bodmin it says near by is the village of St. Lawrence. On the front of a poor dwelling, facing the market house, is placed a tablet with the following inscription: 'Richard Carter, of St. Columb, Merchant, by his last will and testament in anno domini 1582, did give 10 pounds for the assurance of 20 shillings yearly, to be paid unto us, the poor lepers of the Hospital and our successors for ever: which 10 pounds, by the consent of his executors we have employed towards the making of this house anno domini 1586, whose charitable and rare example in our time, God grant may be followed hereafter.' This lazaret house was incorporated by Queen Elizabeth and had a charter. The last patient died in 1800. The last holders, finding the house in disrepair, sold it, and a chancery suit resulted, and the whole incorporation was appropriated by the County Infirmary Fund. In the charter it says, 'These poor men and women to be leprous people and to elect one another.'"

MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

SCHEDULE OF CLINQUES AND LECTURES

From **APRIL** to **JULY**, 1902.

Cliniques at 4 p.m.

MONDAYS. (Skin)	TUESDAYS. (Medical)	WEDNESDAYS. (Surgical)	THURSDAYS. (Surgical)	FRIDAYS. (Eye, Ear, Nose, and Throat)
			April 3 Mr. Hutchinson	April 4 Dr. Herbert Tilley
April 7 Dr. J. M. H. MacLeod	April 8 Dr. James Taylor	April 9 Mr. J. Hutchinson, Junnr.	April 10 Mr. Hutchinson	April 11 Mr. R. Lake
April 14 Dr. T. Colcott Fox	April 15 Dr. W. Ewart	April 16 Mr. Howard Marsh	April 17 Mr. Hutchinson	April 18 Mr. N. MacLehose
April 21 Dr. A. Whitfield	April 22 Dr. Harry Campbell	April 23 Mr. Jackson Clarke	April 24 Mr. Hutchinson	April 25 Dr. St. Clair Thomson
April 28 Dr. J. Galloway	April 29 Dr. Seymour Taylor	April 30 Mr. J. Berry	May 1 Mr. Hutchinson	May 2 Mr. P. R. W. De Santi
May 5 Dr. J. F. Payne	May 6 Dr. Theo. Williams	May 7 Mr. J. Hutchinson, Junnr.	May 8 Mr. Hutchinson	May 9 Mr. Marcus Gunn
May 12 Dr. A. Whitfield	May 13 Sir Wm. Broadbent	May 14 Mr. A. H. Tubby	May 15 Mr. Hutchinson	May 16 Dr. Herbert Tilley
May 19 <i>Whit Monday</i>	May 20 Dr. W. Ewart	May 21 Mr. J. Cantlie	May 22 Mr. Hutchinson	May 23 Dr. Dundas Grant
May 26 Dr. J. F. Payne	May 27 Dr. R. L. Bowles	May 28 Mr. A. H. Tubby	May 29 Mr. Hutchinson	May 30 Mr. Ernest Clarke
June 2 Dr. J. J. Pringle	June 3 Dr. James Taylor	June 4 Mr. Jackson Clarke	June 5 Mr. Hutchinson	June 6 Dr. Jobson Horne
June 9 Dr. T. Colcott Fox	June 10 Sir Wm. Broadbent	June 11 Mr. P. J. Freyer	June 12 Mr. Hutchinson	June 13 Mr. R. Lake
June 16 Dr. A. Whitfield	June 17 Dr. C. O. Hawthorne	June 18 Mr. E. W. Roughton	June 19 Mr. Hutchinson	June 20 Mr. Work Dodd
June 23 Dr. J. M. H. MacLeod	June 24 Dr. Guthrie Rankin	June 25	June 26 Coronation Day	June 27
June 30 Dr. J. F. Payne	July 1 Dr. Theo. Williams	July 2 Mr. Reg. Harrison	July 3 Mr. Hutchinson	July 4 Dr. Dundas Grant
July 7 Dr. T. Colcott Fox	July 8 Dr. Seymour Taylor	July 9 Mr. J. Berry	July 10 Mr. Hutchinson	July 11 Mr. Treacher Collins
July 14 Dr. J. Galloway	July 15 Dr. J. E. Squire	July 16 Mr. J. Cantlie	July 17 Mr. Hutchinson	July 18 Dr. St. Clair Thomson
July 21 Dr. E. Graham Little	July 22 Dr. Harry Campbell	July 23 Mr. Johnson Smith	July 24 Mr. Hutchinson	July 25 <i>College closes.</i>

Clinical Lectures at 5.15 p.m.

April 23rd.—F. W. Mott, Esq., M.D., F.R.C.P., F.R.S.
May 7th.—Sir John Batty Tuke, M.P., M.D., F.R.C.P.
May 21st.—J. Bland-Sutton, Esq., F.R.C.S.
June 4th.—C. Theodore Williams, Esq., M.D., F.R.C.P.

June 18th.—Frederic Eve, Esq., F.R.C.S.
July 2nd.—W. Hale White, Esq., M.D., F.R.C.P.
July 16th.—Sir Anderson Critchett, M.A., F.R.C.S. Ed.

Special Courses of Lectures at 5.15 p.m.

April 18th, 25th, and May 2nd.—Dr. William Hunter, "The Nature and Etiology of Pernicious Anæmia" (with lantern demonstrations).
May 5th and 12th.—Dr. Hugh Playfair, "The Hamorrhages of Pregnancy."
May 9th, 23rd and 30th.—Dr. Jobson Horne, "Tuberculosis of the Ear, Nose, and Throat."

May 26th, June 2nd and 9th.—Mr. F. C. Wallis, "The Diagnosis and Treatment of Rectal Diseases."
June 6th, 13th and 20th.—Mr. Charles Ryall, "Cancer of the Breast, and its Treatment."
June 16th, 23rd and 30th.—Dr. Alexander Morison, "The Nature, Causes, and Treatment of Cardiac Pain."

A. E. HAYWARD PINCH, F.R.C.S., Medical Superintendent.



G. Armauer Hansen

THE POLYCLINIC

BEING THE
JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. VI., No. 7.—JULY, 1902.

THE LEPROSY DEBATE.

THE discussion on Leprosy at the Royal Medical and Chirurgical Society is now a thing of the past. This distinguished Society devoted one evening to the reading of papers and another to a debate upon them, and we may naturally ask, What has been the result? Have we gained any new knowledge or any increased clearness of view? We will leave aside the papers themselves, for they will be permanently in the hands of the profession. The results of the discussion will, however, be more ephemeral, and concerning them we may perhaps profitably say a few words. They were in some senses very disappointing. The speakers did not deal much with the propositions brought forward in the papers, and contented themselves for the most part with simple assertions of their own opinions. There was little or no real attempt to deal comprehensively with the subject. The figures produced by Dr. Hansen, which show that, under what are called in Norway "segregation measures," the disease is rapidly diminishing, naturally exerted a very great effect. To many minds they seemed to prevent the perception of any other class of facts. Dr. Hansen admitted that it was this most satisfactory result which supplied almost the only evidence as to contagion which he could produce. To him, and to most of those who heard him, it seemed to be conclusive, and

speaker after speaker avowed belief in contagion as the sole cause of leprosy and isolation as its sole remedy. No attempt was made to diminish the difficulties which attend the acceptance of this simple creed. One speaker again referred to the old story that the Crusaders brought leprosy into Europe, a story which ignores the fact that not only lepers, but leper-houses, were abundant in Europe and in England several centuries prior to the Crusades. The same speaker adverted to the leper-houses of the Middle Ages as having been the means of exterminating leprosy, in forgetfulness, apparently, of the now well-established facts that they were not places of compulsory isolation, but homes of refuge provided by the benevolent, into which it was a privilege to gain entry; that they did not receive more than a portion of the lepers of their several districts; and that the penalty for misbehaviour on the part of an inmate was not to keep him in, but to turn him out. Another speaker, with complacent satisfaction, narrated the case of a well-to-do man in Cape Colony who became the subject of leprosy without having, so far as he knew, ever seen a leper, but who, some time later, discovered that his groom had been developing the disease at the same time, without being aware of it. This was supposed to prove contagion, and to show that in the alleged *de novo* cases the unfortunate victim might have been exposed to risk without knowing it. The reply of the believer in food-communication is, obviously, that in all probability master and man had eaten of the same parcel of salted fish. No notice was taken of the consideration—admitted even by almost all contagionists—that leprosy in its very early stages is probably not communicable, and that if such infection were possible the groom ought to have given it to dozens of his comrades more likely than to his master, and that the master in turn ought to have infected half his family before he found it out. Were the infection of leprosy as easy as this narrative would suggest, the future for South Africa would indeed be gloomy, and the only course open to a wise man would be absolute avoidance of its pest-stricken population.

By far the most important contribution to the debate was made by Dr. Manson. Not only did Dr. Manson state that he had been informed by some bacteriological friends that they had obtained an approach to cultivation of the leprosy bacillus by the use of a fish medium, but he recorded his acceptance of the creed that the

facts as regards leprosy and tuberculosis are closely similar. The acceptance, by such an authority as Dr. Manson, of this creed, constitutes a most valuable step in advance, and especially when it comes simultaneously with the strong avowal by Dr. Hansen that the bacilli of the two diseases, when isolated, are not distinguishable by any constant characters. That there is a close parallelism between these two constitutional affections has been asserted repeatedly, and by more than one observer. It has even been not obscurely hinted that the one may be a modified form of the other. Should this creed gain the general acceptance of the profession, our ideas as to leprosy will be immensely simplified. The duty of maintaining that it can only spread by external contagion, which some at present seem to feel so binding, will cease to oppress us, and it will be recognised that as in tuberculosis so in leprosy, the modes by which the bacillus is transferred may be various, and that amongst them its presence in articles of food may be one. We shall then dispassionately set ourselves to enquire what articles of food are to be suspected, and the conclusion, one of such momentous import for thousands, may probably soon be reached.

The following is an abstract of the paper referred to in the discussion to which the above remarks apply :—

ON LEPROSY IN CAPE COLONY AND NATAL.

By Jonathan Hutchinson.

[Abstract.]

THIS paper is based upon the experience gained during a tour in Cape Colony and Natal, in the months of December, January, February, and March ult. The tour was undertaken in order to examine as to the prevalence and distribution of leprosy in South Africa, and more especially as to its connection or otherwise with the Cape fish-curing trade. The author visited the large leper establishments of Robben Island and Emjanyana, and also, especially in Natal, examined many lepers at their own homes. He had throughout the cordial and efficient assistance of the respective governments, and desires to acknowledge especially the help of Dr. Britwell at Durban, Dr. Ernest Hill, the medical officer of health to Natal Colony, Dr. Cassidy at Emjanyana, and Dr. Black and Dr. Benjamin on Robben Island. He also visited fish-curing establishments and retail shops in various districts.

The conclusions arrived at are :—

(1) That leprosy was almost, if not absolutely, unknown in South Africa before the Dutch occupation of the Cape.

(2) That before the record of the first cases, the Dutch had brought over Malays from Java to establish a fish factory at Cape Town.

(3) That salt fish with rice was the staple food of the Dutch farmers and their Hottentot slaves at the time that leprosy was first observed.

(4) That the first cases were Dutch farmers living twenty miles inland from Cape Town, concerning whom there is not the least hint that they had been exposed to contagion.

(5) That since 1750, when the first cases were observed, the disease has gradually spread. It advanced around Cape Town in the first instance, but ultimately over almost the whole of what is now British territory, including the Free State and the Transvaal. Quite recently (sixty years) it has crossed the Drakensberg, and advanced into Natal.

(6) In the first instance, Dutch colonists and the mixed race of Hottentot bastards were the chief sufferers, but of late the Bantu races (Kafirs) have been affected.

(7) That the disease has prevailed but very slightly in towns, and has affected chiefly agricultural labourers.

(8) That as usual the male sex has suffered disproportionately (three to two).

(9) That the disease although very widely spread is unequally distributed, but quite without the development of any special centres.

(10) That throughout Cape Colony, the use, as food, of badly cured salt-fish has prevailed widely, especially amongst the agricultural and mining populations, and in ratio, of course, with facilities of transport and local habits.

(11) That in Cape Colony a very large majority of cases are, so far as evidence can be obtained, *de novo* ones, that is, there is no history of either hereditary transmission or of exposure to risk of contagion.

(12) That in the Kafir kraals of Natal there is good reason to believe that the disease is communicated from person to person, especially to young children.

(13) That the rarity and extreme irregularity with which such communication appears to occur suggest that it is neither by inhalation, nor by any sort of skin inoculation.

(14) The author suggests that the mode of communication is by eating food direct from a leper's hand and contaminated by secretions containing the living bacillus. This it is proposed to call "commensal communication."

(15) It would seem probable that in Cape Colony the *de novo* production of the disease by the use of salt fish has been the common cause of the disease, whilst in Natal commensal communication has been more frequent.

(16) That the introduction of the disease into the Kafir kraals of Natal has always been made by some native who, having been into Cape Colony to work, has there acquired the disease either by commensal communication, or more probably by eating salt fish.

(17) The two hypotheses of fish-production and commensal communication taken together satisfactorily explain several difficulties which have hitherto been felt in reference to leprosy. For instance, the non-occurrence of spreading in well civilised communities, and its irregularity and uncertainty even amongst the most careless; the frequency with which young children suffer; the universally observed but varying disproportion of the sexes; the scattered distribution of the disease without (in the case of South Africa) any foci of great prevalence.

The author leaves aside for the present the consideration of the practical measures for the suppression of leprosy which would arise from acceptance of his views.

ARSENIC AND CANCER.

THE suggestion that arsenic has played a part, and possibly not an unimportant one, in the recent increase of cancer, finds suggestive illustrations on all sides. Dr. Solomon Smith writes to us to ask attention to the fact that soot contains arsenic, and that in this way its well-known influence in producing cancer may now be explained. Should this be accepted, a paragraph in an article on cancer in the new volume of the "Encyclopædia Britannica" will read almost like a prophecy. After discussing the influence of vocation upon the incidence of cancer, Dr. Shadwell concludes by saying that nothing is proved excepting the one fact that chimney-sweeps are far more liable to it than others. He adds: "The soot is supposed to act as an irritant; but, if so, why are potters and coal-miners, who also work in irritating materials, so very low in the cancer scale? No doubt the case of the chimney-sweep contains one of the keys to the problem of cancer causation, but it has not been found yet." Now, possibly, in the suggestion as to arsenic, the key has been found. The Registrar-General's statistics, which show that the avocation of chimney-sweep is by very far the most dangerous one, give us also some other not unimportant hints. Next to the sweeps come innkeepers in London, brewers, servants in inns, commercial travellers, and maltsters (in this order). Now, it may be suggested that all these are likely to have been exposed to the influence of arsenical beer, and in this respect probably contrast strongly with grocers, clergy, potters, coal-miners, and farmers, who head the list with minimum records. The Registrar-General tells us that, contrasting the annual averages of the ten years period 1861-70 with the seven years one from 1891-97, the increase in deaths from cancer was, in males 136 per cent., and in females 70 per cent. Thus in thirty years the prevalence of cancer in males had more than doubled. Dr. Shadwell, in the article from which we have already quoted, remarks that no reason can be assigned for this disproportionate increase in men, "except that

cancer in men is more often internal and difficult of diagnosis, and was therefore less frequently diagnosed in former years."

The statistics carefully kept for twenty-seven years at Frankfort are supposed to show that cancer in "accessible parts" has not increased in men, the increase having been in those which are "inaccessible." We need, however, explanation in detail as to the meanings attached to these terms, and the precise conditions under which the facts were collected, before we can attach much importance to them.

The facts in reference to the topographical distribution of cancer in England and Wales, so laboriously collected and analysed by Mr. Haviland, must now be investigated anew. The conclusions at which he arrived as to the influence of river valleys and clay soils in favouring the development of cancer have never, probably, been regarded with much favour. His facts, however, remain, and are of interest and importance. We must now ask whether, in what have been called "Cancer fields," any differences in social customs prevail which can in any degree be made to explain the facts. First, of course, comes the ratio of longevity, but next we have to ask as to beer-drinking, the use of stoves fed with coke, and the prevalent taste as regards wall-papers.

The facts which have been recorded by Mr. D'Arcy Power and others, in reference to the possible influence of certain houses in producing cancer, must also now come under revision. It is possible that such houses had arsenical papers, or were in some other way fitted to supply to their inmates an atmosphere containing arsenic.

The suggestion at present made as regards arsenic is, that whether taken medicinally or dietetically (in beer), inhaled as dust or vapour, or applied externally to the skin, it has the effect, often without producing other symptoms of disagreement, of predisposing the tissues to cancerous modes of growth. In all cases, excepting those of external application, all the tissues of the body probably come under this influence. Thus it is not only epithelial cancer which is to be suspected as of arsenical origin, but all forms of malignant growth, internal as well as external. The interval between the exposure and the realisation of its result may be long, and may extend, according to Dr. Radcliffe Crocker's facts and those of some others, over many years. It is obvious that we have

on our hands an inquiry not only of great importance, but also of great difficulty. We must endeavour to avoid hasty conclusions, but at the same time we must fearlessly seek out the facts.¹

THE SEQUEL OF PSORIASIS CASES.

WE would suggest to the members of the Polyclinic, and indeed to the profession generally, to look up their psoriasis cases. Psoriasis is a definite and well-recognised skin affection, and few medical men can have been long in practice without becoming acquainted with a number of patients suffering from it. What we now want to know is what finally becomes of them. Do they live to old age, or are they liable to any intercurrent maladies which shorten life? Above all, do they die of cancer? The observation that they do sometimes die of cancer was made long before any suspicion was entertained that arsenic caused cancer. Quite independently of any such suspicion, cases had been recorded showing the sequence of the one to the other, and some dermatologists had arrived at the conclusion that there was a bond of connection between the two. Now, of course, we recognise that the bond is the drug which is used. Psoriasis is a very chronic disease; it often occurs at a time of life when its subjects are particularly desirous to be free from blemish; and it may be accepted that, in almost all cases, arsenic has been resorted to in its early stages. If, therefore, it should prove, on enquiry, that any large number of psoriasis patients die ultimately of cancer, the inference will be obvious. A similar enquiry, beginning at the other end, might profitably seek to know how many patients now the subjects of cancer have in former life suffered from psoriasis or other chronic skin disease likely to have induced the use of arsenic.

¹ Those who may wish to read up the subject of Arsenic-Cancer will find the best collection of facts in a short memoir by Dr. M. B. Hartzell, of Pennsylvania, which is reprinted in vol. 170 of the New Sydenham Society's Library. This essay was, however, published in September, 1899, and some important facts have accrued since then.

A GOOD INVESTMENT WITHOUT RISK.

WILL any of our wealthy friends offer a liberal money prize, say five hundred pounds, for the demonstration of the presence of the lepra-bacillus in fish? The search is one of not inconsiderable difficulty, and requiring a large fund of patience. It is therefore very desirable to stimulate industry by an offer which should at least remunerate the investigator for his loss of time. Our Polyclinic committee on leprosy would be glad to name adjudicators who should decide as to the conclusiveness of the demonstration. If the search should be unsuccessful, the prize-giver would lose nothing; but if otherwise, he would have the satisfaction of knowing that he had helped forward a discovery of the utmost possible value to the human race. Dr. Hansen gave us at the Polyclinic some calculations in proof that leper asylums, although expensive, were a source of great profit to the State, in that they tended to prevent a disabling disease. It was of course easy to show that the money gain from the prevention of leprosy was enormous. If, however, it can be made evident that these Institutions are not needed, and that all that is wanted is legislative control over the processes in use for the curing of fish, the financial triumph will be yet more splendid, to say nothing of the prevention of untold misery to countless men, women and children.

A CASE OF PROTRACTED LEPROSY IN IRELAND.

DR. O'CARROLL published in 1889, in the *Transactions of the Royal Academy of Medicine of Ireland*, a case of leprosy which he had observed with great care. The patient was an Irish soldier who had served in India and China, but who had resided in Ireland for the last eighteen years. His leprosy had probably begun about twenty years before. It had progressed slowly, but in the usual way, with skin eruptions, anæsthesia, nerve affections, tubercles, and some mutilation of the extremities. After this prolonged duration, the man still appeared to preserve good general health, and he might,

in fact, be in process of recovery. Dr. O'Carroll found bacilli plentifully. A point of chief interest is the long duration of the case without cachexia. We may also note that, although there had been no sort of seclusion (the disease having, in fact, not been recognised), the man had passed eighteen years in Ireland, and there had been no known contagion; and lastly, that, as is usually the case, he had himself no idea that he had ever received it by contagion. Dr. O'Carroll writes: "He says he does not remember to have seen a leper, or to have heard of leprosy, in his wanderings, nor has he known of its existence, unless from reading the Bible."

At various meetings of the Polyclinic Leprosy Investigation Committee, Dr. Radcliffe Crocker, Dr. Colcott Fox, Dr. Abraham, and Mr. Hutchinson have all detailed their experience of leprosy in England, and all have stated that they have never known it to spread by contagion. Their united experience comprised more than a hundred and thirty cases, and these in all stages, whilst in most of them no special precautions had been observed.

CANCER IN THE SOCIETY OF FRIENDS.

FROM statistical statements which have been supplied to the Editor of the POLYCLINIC by Mr. J. B. Tennant, the courteous Secretary of the Friends' Provident Institution, we learn that during the last twenty years there has been no appreciable increase of cancer in the Society of Friends. This fact is a valuable one, and may help us to assign to its true causes the great increase which is credited to the community at large. The statistics of insurance offices concern almost exclusively adults, and of adults a greatly disproportionate number of those who, if not actually senile, have at any rate passed the meridian of life. Now, it is at these ages that cancer usually occurs, and their records of causes of death (usually given with accuracy) become of much value in enabling us to estimate the relative prevalence of that disease from year to year. The tables now before us show that during the period named the

¹ In reply to an enquiry, Dr. O'Carroll has been kind enough to inform us that the man died of senile heart failure about a year after the publication of his case. There had been no contagion to any one.

proportion of deaths from cancer to deaths from all causes has been for males a little more than four per cent., and for females nearly six, and that it was no higher at the end of the period than it was at the beginning. Almost without exception the victims of the disease were advanced in life. The total number of deaths concerned is near upon 1,700. Those insured in this office are probably, with very few exceptions, abstainers from alcohol, and a large majority are non-smokers. The possible influence of arsenical beer as predisposing to cancer, and that of smoking as exciting it, have therefore not been felt. It would be of great interest to compare the figures we have given with those of other insurance societies.

SUPPOSED INCREASE IN THE MEDICINAL USE OF ARSENIC.

THERE is a prevalent, and probably correct, impression in the profession that the medicinal use of arsenic has very much increased of late years. Wishing to test its validity, we have made application to the renowned dispensers, Messrs. Allen and Hanbury, of Plough Court, and also to the Apothecaries' Company. From both we have received courteous replies. Mr. Cornelius Hanbury, the present head of the Plough Court establishment, was good enough to have their filed prescriptions examined from the year 1861 to the present time. The result shows that during 1861 arsenic occurred once in every 81, in 1874 once in every 56, and in 1901 once in every 14. We would be far from wishing to suggest that these figures prove what they seem to imply, for there are possible fallacies, and the enquiry must be conducted on a larger scale before any trustworthy conclusions can be arrived at. We are, however, in all probability justified in believing that they indicate a large increase in the medicinal use of arsenic during the last half-century. It is possible, however, that the increase has already ceased to be progressive. Statistics taken at Messrs. Allen and Hanbury's West-end house in Vere Street show no increase in 1892, but rather the reverse, as compared with 1887. Instead of showing the presence of arsenic in one out of every 14 prescriptions, as at Plough Court in 1901, the Vere Street ones show only one in 25. From the Apothecaries'

Company we have no figures, but only a general statement that it is thought probable that the use of arsenic has increased.

We have made enquiry also as to whether there is in England much of what may be called the unauthorised employment of arsenic as a drug. The replies of those well qualified to judge is that this does not prevail to any large extent. There is not much borrowing of prescriptions containing this drug, nor—although many French drops and globules contain it—is there any secret preparation of similar kind in use in England.

ESTIMATION OF FREQUENCY OF HERPES ZOSTER.

FOLLOWING up the suggestion made in last month's POLYCLINIC, Mr. T. J. Hitchins has been endeavouring to estimate the prevalence of herpes zoster at different hospitals. He finds the statistical tables supplied from St. Thomas's Hospital more available for the purpose than those of any other. This hospital registers a total of skin cases varying annually from 622 to 792, and the proportion of zoster cases is 1·2 per cent. Males preponderate in the proportion of 43 to 28, the total being 71. The period is from 1889 to 1899, both included. In his own hospital practice (that of St. Francis), Mr. Hitchins finds that in a total of 2,375 cases 18 of zoster occurred—a ratio of 1·1 per cent. Two were taking arsenic at the time. We shall be much obliged to any other of our members who can supply statistics on this subject.

DR. HANSEN AT A MEETING OF THE LEPROSY COMMITTEE.

A MEETING of the Leprosy Committee was held in the Council Room on Thursday, June 12, Dr. Radcliffe Crocker in the chair. Amongst members of the committee present were Sir William Kynsey, Dr. Abraham and Mr. Hutchinson. The chief object of the meeting was to receive Dr. Hansen, who had kindly consented to attend and answer any enquiries as to the history and present condition of leprosy in Norway. Before calling upon Dr. Hansen,

the Chairman asked Dr. Abraham to demonstrate a case which he had brought.

Dr. Abraham's patient was a young lady from South Africa, who had acquired her disease in that country. No conjecture could be formed as to how she had got it, for it was not believed that she had ever been in any way exposed to the risk of contagion. It was of the macular form and it was believed to be very definitely receding under treatment by chaulmoogra oil. The Chairman pointed out that the doses which Dr. Abraham was using were only small ones.

Dr. Hansen, who was very warmly received, then proceeded to make a statement as to the present position of leprosy in Norway. Briefly, he said, there was reason to believe that in 1856 there were 2,870 lepers in Norway, and that now there were not more than four or five hundred. He attributed this result entirely to isolation in asylums of a certain proportion, and to the care which had been taken to persuade the peasants in leprosy districts to be more careful as to intercourse between the healthy and diseased. In reply to a subsequent question, he said that the number of lepers still at their own homes was about a third of the whole, whilst two-thirds he thought were in the asylums, either at Bergen or Trondhjem. He explained that although the first laws as to leprosy were enacted in 1878, the present and more efficient law dated only from 1885. Under this latter any community wishing to send its lepers to an asylum could do so, and they would be maintained in comfort at the public expense. In reply to another questioner, Dr. Hansen explained that no central jurisdiction over lepers was exercised. It rested with the local authority to enforce removal of the leper from his home if it was thought desirable. This was only done if it was thought that reasonable conditions of isolation at home could not be attained. Asked what were considered "reasonable conditions," Dr. Hansen replied that in the first place the patient must have a bed to himself, he must eat at a separate table, he must observe strict cleanliness and not allow other members of the family to wear his clothes. It had been very necessary to educate the peasant farmers to an appreciation of the danger which attended association with lepers. Formerly they had been quite careless and, although as regards the healthy a much improved state of caution had been reached, it was still most difficult to induce the lepers themselves

to regard their persons as causes of danger to others. He was acquainted, he said, with a recent instance in which a farmer who was a leper had found it difficult to get servants to live in his home, whereas formerly no one would have objected. This showed advance in knowledge which was certain to lead to good results.

The question having been asked whether in the case of a married couple, one of whom had become a leper, the occupation of separate beds was enforced, Dr. Hansen said that it was not, and remarked that it was a very puzzling fact as regards leprosy that husband and wife very seldom suffered together. There were many matters respecting leprosy which as yet our facts did not enable us to explain, and this was one of them.

The Chairman asked Dr. Hansen whether he could mention any instances in which the evidence of contagion was strong; and another member of the Committee added an enquiry whether the disease ever spread amongst the population of Bergen itself or the attendants at its two leper asylums. Dr. Hansen replied that for many years there had not been any instance of a Bergen resident becoming affected with leprosy, nor during the whole period of their existence had there been any case amongst the nurses or servants or staffs of the asylums, with the single exception of one washerwoman. It was not at all uncommon for young persons to come from leprosy districts in the country to find places as servants in Bergen, and amongst these no cases of the disease had ever, within his knowledge, developed. It was difficult in the country districts to get trustworthy information as to exposure to contagion, for he was sorry to say lepers were as a rule not truthful, many who denied having been exposed to risk of contagion had probably been so. This could not unfrequently be proved. He believed that the disease was always spread by contagion and never by hereditary transmission. He related a case in which the disease had affected in succession a number of individuals in the same family under conditions strongly suggestive of contagion.

In answer to the question as to the vocation and place of residence of this family, Dr. Hansen replied that they lived in the mountains, and the men combined the occupations of farmer and fisherman, adding "as almost all the Norwegian peasants on the West coast do." In the olden time, he said, there had been lepers

in the Bergen population who had developed their disease whilst residing there, but none such had occurred recently, and for very long no anxiety whatever had been felt by the better classes of the community as to catching the disease. He knew of only one instance of a stranger becoming a leper, and in that instance the man was a German officer who degraded himself, was intemperate, and lived with the fishermen and ate their food. He expressed great confidence in cleanliness as preventive of leprosy, and said that those who would take ordinary care of themselves in this matter and not sleep with lepers nor wear lepers' clothes need not fear. He did not think that segregation homes were at all requisite in England, because in England all needful care would be taken in these matters.

Dr. Hansen was next asked to state the results of his visit to the United States in order to investigate the facts as to the lepers who had immigrated from Norway. He said that he had spent ten months in the tour, chiefly in Minnesota and Dakota, and that he had received information of 170 cases. Of these he was able to find, still living, only fifteen, but he saw the children and in some instances the grandchildren and even great grandchildren of lepers and found them all healthy. Most of those whom he could not trace were probably dead. The facts which he obtained enabled him to feel quite sure that the disease was not hereditary.

"But, did they not equally convince you that it was not contagious? Did you find any cases in which the disease had been communicated to others?" To this Dr. Hansen replied that it was true that no evidence as to contagion could be obtained in America, and there appeared to be something in the conditions of life there which prevented a malady which was contagious in Norway from spreading in that way in the States. He explained the difference by suggesting that the houses were larger, there were more beds and less crowding, and that the habits of all were more cleanly. He had found no instance in which an American had been infected, but he had found one in which a Norwegian had become affected whilst living in America and in the family of a leper. He did not think that it was an instance of prolonged incubation and that the man had really brought the bacillus with him from Norway, because the interval was too long. He expressed some incredulity as to the very long periods of incubation which had been suggested by some authors. At the

same time he fully admitted that the lepra-bacillus appeared to be under many circumstances a very innocent one. It often remained in the tissues for long periods without causing any irritation whatever. Quite recently, in cases of anæsthetic leprosy which had been supposed to have undergone cure and in which for a long time no symptoms had been developed, the bacillus had been recognised by the microscope in the nerves and spinal cord, apparently in a quite quiescent state. These observations had been made by Dr. Lie, of Bergen, and would soon be published. They made it clear that we could never speak of a case of leprosy as really cured. This statement led to the question being put as to whether in leprosy asylums of Bergen, the patients were ever liberated as "cured" or whether they remained there for life. "Practically," replied Dr. Hansen, "they are all there for life. They are made comfortable, and generally do not wish to leave, and their friends would not welcome them home. If one should insist on returning we cannot prevent it, but it is very rarely the question arises."

As to the prolificacy of lepers, respecting which the Chairman made enquiries, Dr. Hansen said that he had seen no reason to think that they differed from other people. Amongst the peasants who were lepers and who were allowed to remain at their homes, there were many who had children, and in some instances large families. The notion that the disease was hereditary, which had so much occupied Dr. Danielsen's mind, had now been quite abandoned, and no fear was now entertained on that score.

The Chairman next asked Dr. Hansen to state his experience as to the treatment of leprosy. "For myself," he replied, "I do not believe that anything does any material good, and I never use any remedies excepting attention by ordinary measures to the sores, and to the general health. We have at Bergen tried everything in turn, and have abandoned all. We have no faith in chaulmoogra oil, and never use it. Recently Dr. Lie, one of my colleagues, has believed that he obtained benefit from the use of mercury, as recommended by Dr. Radcliffe Crocker; but for myself I am not convinced. I do not think that anything does any special good. In Norway we aim at prevention, not at cure, and the one measure in which I have faith is isolation."

Mr. Hutchinson now drew Dr. Hansen's attention to the fact

that leprosy was diminishing in Madeira quite as rapidly as in Norway, and without any isolation measures whatever. There was a large, well-kept leprosy home which could receive thirty patients, but recently he (Mr. H.) had found on visiting it, only three inmates. The record of a former visitor forty years ago, was eighteen. Into this home the patients were free to enter if they liked, and to leave it when they liked, but they were made comfortable, and some preferred to remain. He suggested that what was taking place in Norway now was parallel with what was occurring in Madeira, and with what occurred during the latter part of the Middle Ages; over the greater part of Europe the disease was dying out. He also thought that the decline in Norway had begun long before what was called isolation had been commenced, and before the leper laws were passed.

Dr. Hansen replied that he could not doubt that the leprosy laws, and care as to avoidance of contagion, had greatly accelerated the decline of leprosy in Norway. In former days there was no accurate estimate of the numbers; now the cases were carefully sought out and counted, and the friends of the patients duly warned. As to the decline of leprosy in populations in which there was no attempt at isolation, it was only one of the many problems which awaited further investigation. If everything were as clear as that two and two make four, the pursuits of the physician would lose their interest, and medical life would be insupportably dull. It was certainly not so yet as regards leprosy, and that was why the study of that disease was so attractive to so many. The discovery of the bacillus had, he hoped, done something to clear the way, but there was plenty left to engage the industry of the next generation of workers.

The meeting terminated by a hearty vote of thanks to Dr. Hansen for his kindness in attending and in submitting to cross-examination.

TO INTENDING NEW MEMBERS.

WE wish to draw attention to the fact that the Council has decided that after January 1, 1903, there shall be an admission fee of one guinea payable by all new members. Those joining now will escape this, and will secure the Journal for the whole of the current year.

THE KING'S ILLNESS.

FOR the convenience of our readers we have here displayed the chief events in the King's illness in the space-for-time method. His Majesty is now, we may thankfully believe, out of danger.

June

13. *Friday*.—Much fatigued and went early to bed.
14. *Saturday*.—In the morning complained of abdominal discomfort. Seen by Sir F. Laking. Went to Aldershot and slept there.
15. *Sunday*.—Sir F. Laking summoned to Aldershot at 5 a.m. on account of abdominal pain. Seen by Sir T. Barlow. A mild rigor in afternoon.
16. *Monday*.—Travelled by carriage to Windsor and bore the journey well.
17. *Tuesday*.—Gave up Ascot and remained on couch most of the day, but took a short drive in private grounds.
18. *Wednesday*.—Seen by Sir F. Treves for first time. Temperature elevated. Swelling and tenderness in right iliac fossa.
19. *Thursday*.—Better. Temperature normal.
20. *Friday*.—Doing well. Local symptoms less marked. Temperature normal.
21. *Saturday*.—Seen for second time by Sir F. Treves. Temperature normal. Swelling nearly vanished.
22. *Sunday*.—Uneventful.
23. *Monday*.—Travelled by rail from Windsor to London. On arrival seen by Sir F. Treves. Symptoms increased and abscess suspected.
24. *Tuesday*.—At 10 a.m., consultation with Lord Lister and Sir T. Smith. Operation performed soon after noon. Abscess evacuated.
25. *Wednesday*.—As well as could be expected, but restless.
26. *Thursday*.—Better.
27. *Friday*.—Doing well. Temperature normal.
28. *Saturday*.—Doing well.
29. *Sunday*.—Free from immediate danger.
30. *Monday*.—Doing well, but dressings painful. (Subsequent progress good).

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ON BRONCHIAL ASTHMA.

BY C. THEODORE WILLIAMS, M.D., F.R.C.P.

[*Abstract.*]

BRONCHIAL asthma is a comparatively common disease, which, though rarely or never directly threatening life, causes the patient much discomfort and inconvenience, and tends sooner or later to produce serious structural changes in the respiratory and circulatory mechanisms. It is frequently seen in those employed in trades associated with the production of much dust, and is not uncommon in children. In many of the sufferers it is difficult or impossible to trace the immediate cause, whilst in others there is a definite relationship between the attacks of the disease and the inhalation of some irritating agent. The temporary and evanescent nature of the seizures explains the absence of patients suffering with asthma from the wards of the general hospitals until, at least, the disease has produced complications of a more or less serious nature. Hence it happens that, for the most part, the student gains no practical acquaintance with the treatment of asthma until he accepts the responsibilities of private practice. The typical attack of bronchial asthma is distinguished by its sudden onset and temporary duration, the patient in the interval between successive attacks being in good health and free from discomfort. For the most part, the attack comes on during the night. The patient retires to bed in his usual health. Either immediately on lying down, or more frequently after sleeping for a time, he feels an oppression in his chest, and becomes conscious of some difficulty in breathing, and finds himself

compelled to sit up in bed in order to get breath. All his attention and energy are set on this one object. The appearance of his face betrays his anxiety. All the inspiratory muscles he can command are put into energetic action, whilst by fixing his upper limbs, as by seizing the back of a chair or some similar manœuvre, he compels muscles which normally move the limb on the trunk to act as elevators of the ribs. In spite of all this effort, however, he fails to communicate much movement to his chest wall, which rather remains fixed in the position of deep inspiration. Physical examination gives an unduly resonant percussion note, with the resonance extending into the normal areas of cardiac and hepatic dulness. On auscultation numerous rhonchi—snoring, piping, sibilant—will be heard, the situation and distribution of these varying from moment to moment. It is the vagrancy of these sounds which is the leading diagnostic note of the disease. The complete disappearance of all adventitious sounds from an area which a moment or so before was loud with all kinds of musical rhonchi, is an event which an asthmatic spasm is alone competent to explain. The dyspnoea may proceed to an extreme degree, and may thus produce considerable cyanosis. But when it reaches its height it will inevitably begin to decline. Gradually respiratory movement returns to the chest, and the patient experiences relief and often falls into an easy sleep. Often the decline is accompanied by the voiding of a considerable quantity of pale, watery urine, and sometimes by the expectoration of mucus having a “sago-grain” appearance. In the expectoration may be found colourless, glancing crystals, octahedral in shape—the Charcot-Leyden crystals—and also curious twisted masses of mucus known as Curschmann’s spirals. When the patient awakes in the morning after the attack he is, in a typical attack of uncomplicated asthma, quite well, and remains so until the next seizure. But when frequently repeated, the asthmatic attacks produce pulmonary emphysema, with its necessary accompaniment of permanent breathlessness. Sooner or later, too, there follows dilatation of the right ventricle of the heart, the results of which are apt to be seen in the development of œdema and albuminuria.

Regarding the causes of asthma, the condition in some cases is found to be excited by the inhalation of dust, and different individuals have marked idiosyncrasies in this respect. The pollen of

various flowers, dust from sweeping a carpet, making a bed, etc., may be quoted as examples of local irritants. Other patients are susceptible to particular odours, animal emanations, etc. Climatic conditions also have their part in the production of asthma, and the disease is frequent in the close valleys of certain districts in the West of England. Catarrhal states of the bronchial passages, as in measles and whooping-cough, are predisposing agencies. The asthmatic tendency may also be excited through the nervous system. Fright or passion may thus bring on an attack. Peripheral irritation, as, for example, that produced by nasal polypi, may be the cause. A gouty habit of body may express itself in the form of asthma, and heredity has a very prominent position in the causation of the disease.

The *pathology* of asthma has its first fact in a spasm of the muscular fibres in the walls of the bronchial tubes. These and the bronchial mucous membrane are both innervated from the pulmonary plexuses. The posterior pulmonary plexuses of nerves is in close anatomical relationship with the group of lymphatic glands situated at the bifurcation of the trachea. The enlargement of these glands, when it occurs, will tend to irritate and make more sensitive the nerves distributed to the bronchial passages, so that under slight irritation, whether locally by inhaled dust or otherwise, bronchial muscular spasm will be produced. In the recumbent posture there is an added tendency to congestion of the lymphatic glands in the posterior mediastinum, and doubtless this is an influence explaining, at least in part, the nocturnal character of the asthmatic attacks. Again, many asthmatic children lose their asthma on reaching adolescence, a fact probably due to diminution in the size and activity of the glands near the root of the lung as part of a general decline in the prominence of the glandular system.

The *diagnosis* of asthma is readily made from the obviously spasmodic nature of the affection. There is neither the permanent breathlessness of emphysema nor the persistent auscultatory phenomena of bronchitis. Croup is another disease having a spasmodic character, but it is marked by laryngeal stridor, and the respiratory difficulty is inspiratory, whereas in asthma it is expiratory. Very exceptionally a small aortic aneurism may fail to give much evidence of its existence other than a series of asthmatic

seizures due to pressure on the pulmonary plexus of nerves ; in such a case examination of the larynx would probably show some paresis of the left vocal cord, due to involvement of the recurrent laryngeal nerve. Another possible error is to overlook a case of fibroid phthisis. When asthma develops in a patient in whom a pulmonary tuberculosis has been followed by considerable fibrosis, it is probably due to the pressure of fibrotic masses on the pulmonary plexuses. Unless the history of the case is carefully investigated, more especially in reference to hæmoptysis, it would be easy to err both in diagnosis and prognosis. The *prognosis* of the individual asthmatic paroxysm is quite favourable. However threatening the cyanosis and collapse may appear, the patient will certainly recover, the accumulation of carbon dioxide in the blood leading to relaxation of the muscular spasm. Of the future prospects of the patient it may be said that the disease is not likely to kill him, at least directly, though its persistence will certainly damage both his lungs and his heart. When emphysema has definitely developed, the outlook is less promising. Children, as a rule, recover from asthma as they reach adult life. When the disease appears for the first time in middle life, the chances of its persistence are considerable.

The *treatment* is dominated by two principles, namely, (1) reduce the spasm ; (2) remove the cause of the attacks. To fulfil the first indication nothing is so successful as the iodide of potassium or sodium. The dose should range from 5 to 15 grains, should be given freely diluted, and be steadily persevered with. Woodhall Spa and other iodised waters are also beneficial. Arsenic is of value in chronic cases. The stramonium group, used by inhalation, are certainly often useful in relieving an attack, but they are apt to generate a habit, and their frequent use undoubtedly weakens the heart ; on the whole, their greatest value is obtained when administered internally. The necessity to give the patient relief in a bad attack is urgent, and morphine hypodermically is often unavoidable. Chloral hydrate in some cases is successful, and chloroform may be used in an emergency.

Dr. Williams concluded his lecture with a description of the compressed air bath, and spoke highly of this method of treatment.

ON A CASE OF ARSENIC-CANCER.

BY JONATHAN HUTCHINSON F.R.S., LL.D.

MR. L., then aged 70, first consulted me on September 29, 1899. He had an ulcer of some standing on the forefinger of his right hand, and another on the back of his right shoulder, just where the brace might have rubbed. Both ulcers were somewhat peculiar in their features, and in association with them was a rough corneous condition of the palms which led me at once to diagnose "arsenic-cancer." At first it was doubted, both by his medical attendant and himself, whether he had ever taken much arsenic, but subsequent investigation proved that he had. I advised immediate amputation of the finger and free excision of the ulcer in his shoulder. After a little delay these operations were done at his home in ——shire, and the specimens were, at my suggestion, forwarded to the Clinical Research Association. I will now read you the Report; it is dated December 13, 1899:—

"Both of these specimens are affected with squamous-celled epithelioma. In the finger the subjacent tissues are deeply infiltrated, and there is advanced keratoid change in the epithelial processes. In the ulcer from the back, the epithelioma has penetrated to the level of the subcutaneous fat. The cells in this specimen are smaller and more diffused. There are very few cell-nests here."

(Signed) J. H. TARGETT.

A year later Mr. L. was brought to me again. The scar of the amputation was sound, and so was that on the shoulder, but within an inch or two of the latter, towards the spine, was a rounded subcutaneous tumour, rather soft to the touch, and about as large as a hen's egg. The skin overlying this was absolutely free from change. From the proximity to the scar, we could only believe that it was due to infection from the original ulcer. It was not like a gland, and, as you will see, it was in a position where no gland is present. Our patient thought that a little nodule had been present at the time of the operation, and had been overlooked. I advised excision without delay, and this was again done at the patient's home. I

did not myself ever see the specimen, but I was informed that the microscope proved it to be "soft carcinoma of the acinous type."

Such, then, Gentlemen, is the history of the patient whom I have brought before you to-day. You have seen that the scar of the finger, amputation, in the cleft between thumb and middle finger, although quite free from inflammation, has become horn-like, and that there is, crossing it, a deep crack, which shows a florid surface at the bottom. There is no papillary outgrowth. You have seen and felt that the palms of both hands are roughened by numerous corns, some of which are also present on the sides of his fingers, and even on their backs. About his wrists are some dry, scaly patches like dry eczema. We have not asked him to undress, but I may tell you that the scars of the two excisions on his shoulder are quite healthy, though of considerable extent, excepting that in the middle of the second some induration has recently taken place. There are many little patches of dry and roughened skin on various parts of the trunk and limbs, and a few senile verrucæ on the back. We have looked at his feet. You have seen that his soles are in the same condition as that shown in one of the portraits in our Museum, only not so advanced. They show thickened cuticle on all the parts exposed to pressure, producing what might, were the condition less diffuse, be called very large corns. Over these patches, which involve the whole heel and tread of the front foot, and exempt the arch, there is white desquamation. On the outer side of one foot, quite out of the pressure-area, is a very peculiar patch. The horn-like epidermis is half an inch thick, and stands in columns which are split vertically after the pattern of the Giant's Causeway. These are not papillary, but purely epidermic, as is proved by the fact that they occasionally break off. When they do so, a clean surface is left, from which they are soon reproduced. Two attempts have been made, by the use of caustics, to cure this patch, but without success. To look at our patient's face you would imagine it quite healthy. He looks like a florid, delicate-skinned old man. When, however, you inspect his face critically, you find many little scabrous patches here and there, any one of which may be the beginning of more serious changes. There are a few also on his bald scalp. As regards gland enlargement, there are quite definite glands in both armpits, and also a few very hard but very small ones

in the right posterior triangle of his neck. The latter are found with difficulty. He knew of them himself, or I should have missed them.

I have now only to give you the details as to his former drug treatment, and then you will have before you the full facts as to a very typical example of "arsenic-cancer."

About the age of 20 our patient developed an eruption which persisted a long time, and for which he says that arsenic was given. He does not recollect that it disagreed, and as to doses and length of treatment nothing is certain. This eruption, apparently psoriasis, continued to relapse through his subsequent life, and he was repeatedly for long periods under drug treatment. He does not know what was given him. A few years prior to my first consultation he took arsenic under the advice of a medical man, who has kindly supplied me with details. It was given for his old enemy the eruption. He took seven minims of Fowler's solution three times a day for some months, until it definitely disagreed. The symptoms which it produced were loss of flesh, debility, some numbness in the feet and hands, and buzzing in the ears. It was laid aside for a time, but, as the eruption relapsed, it was, after an interval, again given, and again disagreed. It was from the date of this second course that the keratosis of his palms dates.

My original paper on arsenical cancer was presented to the Pathological Society in 1887, and was published in vol. xxxix., p. 352. At this time I believe that general incredulity was felt as to there being any real connection between the suggested cause and the results. Nor, I must confess, have many confirmatory facts been since collected in England excepting by myself. A few have, however, been put on record at home, on the Continent, and in America. I will mention very briefly the principal ones. Most of them will be found already recorded in my "Archives."

In 1894 Mr. Arbuthnot Lane recorded in the Clinical Society's Transactions¹ a very important case. Its subject was a man, aged 63, who had taken arsenic for the cure of psoriasis almost half his life. In April, 1892, Mr. Lane excised from the back of his forearm an epitheliomatous growth two inches in diameter. In 1893,

¹ Clinical Society's Transactions, vol. xxvii., page 102.

he again applied with three distinct cancerous ulcers on his scrotum, and in December, 1893, and January, 1894, he was again admitted for new ulcers on the same part. Counting the sore on the forearm as four (since it had resulted from the coalescence of four), there had been eleven different foci of these growths. All had been freely excised and all examined microscopically. Unfortunately Mr. Lane does not describe the condition of the palms and soles, or give any particulars as to other symptoms of arsenical disagreement. The arsenic, it will be observed, was stopped in March, 1893, but growths continued to be produced a year later.

At p. 339 of "Archives," vol. v., I have mentioned the case of a gentleman, aged 35, who had three growths excised from different parts during seven years. He had also keratosis of his palms. In this instance an interval of ten years was alleged between the disuse of the arsenic and the development of the epitheliomatous growths. He may, however, have been drinking arsenical beer all the time. The keratosis of the palms occurred soon after the disuse of the arsenic, and persisted.

In vol. ix. of my "Archives," p. 63, the case of a patient brought to me by Dr. Bullock, of Notting Hill, is given. Of this case we have drawings in the Museum. The man was emaciated and very ill, and he died not long after the portraits were taken. In this case the cancer had developed in an old psoriasis patch on the abdomen. It had been ulcerated three years when I saw it, but had not progressed much until the last year. The glands had enlarged and ulcerated. There was an independent ulcer (cancerous) on the back. His hands had become harsh and dry, but no corns had ever formed. He was 46, and had taken arsenic since the age of 14.

At p. 282 of vol. viii. of "Archives," I have mentioned two cases in which tumours in the neck, probably glandular in site, but malignant in their course, occurred to those who had formerly taken long courses of arsenic for skin diseases.

At p. 186 and p. 233 of vol. vi. of "Archives," the case is mentioned of a lady who had taken arsenic for long periods for lupus. In December, 1888, her palms and soles were in a condition of keratosis, and I forbade the further use of arsenic. In July, 1890, her palms and soles had quite recovered. At one time in

1877, whilst taking arsenic, part of the edge of the lupus patch assumed the hard rolled condition of a rodent ulcer. It got well, however, under cauterisation with nitric acid.

At p. 224 of vol. ix. of "Archives" is a very important case. A lady of 45, who had for long suffered from keratosis of her palms, came under my observation with a large isolated growth in her neck. It was as big as a child's fist. It was excised, and proved to be, not sarcomatous, but squamous-celled epithelioma. She had at the same time a growth under the skin in the left mammary region. There were also gland masses in one groin. Thickened and ulcerated portions of skin had on two occasions been excised from her palms, and the wounds left had healed for a time and then relapsed. She died, insane and comatose, four months after I saw her, with suspicion of growths in the skull.

In this case, as soon as I saw the patient's hands, I diagnosed "arsenic-cancer," but at first all history of arsenic having been prescribed was denied. On looking up her old prescriptions, however, it was found that during 1879 and 1880, for twenty months continuously, she had taken ten minims of Fowler's solution per day. It was given for epilepsy. The condition of the palms and soles did not, according to these dates, begin until five years after the conclusion of her arsenical course. From some of her statements, however, I thought it possible that she had, unknown to her medical adviser, taken arsenic both before and after the course referred to.

That the interval between the date of suspension of the arsenic and the first development of keratosis may, however, be prolonged over many years is indicated not only by several of my own cases, but by a remarkable one which has been recorded by Mr. Pernet in the *British Medical Journal* for 1901. The patient was an elderly man, under the care of Dr. Radcliffe Crocker. The case was a typical one of arsenic-cancer, but the arsenic had been taken in early life, and the cancer did not develop until the approach of senility.

(To be concluded.)



Paralysis of the Right Serratus Magnus.
(Dr. Scot Skirving's Case.)



Paralysis of the Right Serratus Magnus.
(*Mr. Hutchinson's Case.*)

PARALYSIS OF THE SERRATUS MAGNUS.

A GOOD photograph, showing the position of the scapula in uncomplicated paralysis of the serratus magnus, has recently been sent to me by Dr. Scot Skirving, of Sydney. In showing it to you I also produce another, which has been long in my possession, since the concurrent testimony of two witnesses is more convincing than that of one. You will see how closely similar the two are.

In my own case the cause of the paralysis was supposed to have been over-exertion of the upper extremity during a severe labour. The woman had strained violently at a rope placed, as usual, above her. The condition was, I believe, permanent. I will read you what I have received respecting the other case:—

PARALYSIS OF THE RIGHT SERRATUS MAGNUS.

The photograph is of the back of a man, in whom there was complete paralysis of the right serratus magnus. He has his right arm adducted and raised to a right angle with his trunk. The condition was suddenly discovered, when one morning he was unable to hold a lamp as high as was required of him.

The patient gave a history of an injury, sustained three weeks before he became aware of his disability; the injury being a blow which he referred to the region of the right supraspinous fossa, but which he said caused him no particular pain, and which left no mark. The blow was due to a heavy fall backwards, the part mentioned coming into contact with the corner (blunt) of a furnace door.

Dr. Scot Skirving, who saw the patient at the St. Vincent's Hospital, Sydney, pointed out the cause of the condition. On examination the digitations of the serratus magnus, which could be easily felt on the sound side, could not be detected on the affected side.

After six weeks' observation and treatment, blistering over the roots of the external respiratory nerve, there was no improvement. No history of syphilis could be obtained.

Paralysis of the serratus magnus apart from other muscles has long been recognised, but is of rare occurrence. More often it is complicated with that of other muscles, as the deltoid and the smaller ones of the shoulder. When alone it is easy of recognition, for the scapula being no longer held closely on the ribs starts away as soon as the arm is lifted. If the arm be supported and quite at rest the condition may be overlooked, and the same may happen if the deltoid be paralysed with it.

Duchenne, after stating that the fact is often overlooked that other muscles are involved with the serratus, describes the true signs of its paralysis as follows: "(1) A rotation on its vertical axis, so that the spinal border separates from the thoracic wall. (2) A tilting movement so that the lower angle rises and nears the middle line, while the outer angle is depressed." This you will see well shown in our portraits. Duchenne continues: "In its most extreme form the scapula projects like a wing from the thorax, and the skin of the back is tucked round the spinal border so as to form a deep gutter."¹ Owing to the depression of glenoid cavity there is much difficulty in raising the arm, and in extreme cases the patient may be obliged to bend his trunk to the opposite side in order to bring the arm into a horizontal position. This may lead an incautious observer to suspect that the deltoid is weak. In early stages, or when the paralysis is only incomplete, the patient should, when stripped, be made to hold both arms out. If when he does so the lower angle is observed not to advance on the chest wall whilst the posterior costa projects it may be assumed that the serratus is weak.

NOTICE.

CLINICAL EXCURSION TO MARGATE.

AN invitation from the Committee and Staff to visit Margate Infirmary for Scrofula has been accepted. The excursion is fixed for next Saturday, July 12, and the rendezvous will be the Seabathing Infirmary at 2.30. Dr. Thornton and other members of the staff have kindly undertaken to meet the excursionists and show their cases. The clinic will last two hours. This institution receives all forms of scrofulous disease, and the demonstration of cases is sure to be of great interest. All members of the Polyclinic are invited, and any of their friends will be welcome. Communications should be addressed to the Honorary Librarian, Dr. Joll, at 22, Chenies Street. Margate may be reached either by road, rail, or steamboat.

¹ See vol. cv. of "New Sydenham Society," page 305. Selections from the Clinical Works of Duchenne. Translated by Dr. Vivian Poore.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY JAMES TAYLOR, M.D., F.R.C.P.

Tuesday, June 3, 1902.

A Case of Unilateral Sweating.

THE patient was a man of about 30 years. The only symptom of which he complained was persistent sweating of the left half of the face, and to a less extent of the left half of the body. This condition had been present between three and four months, and had developed without obvious cause. Dr. Taylor remarked that the fact of the sweating being so widely spread argued some central disturbance, presumably of the centres which exercise vaso-motor control. He quoted a case in which the sweating followed an accident involving some twisting of the cervical spine. In the present case there was no history of injury, and examination failed to detect any abnormal condition likely to interfere with the functions of the cervical sympathetic. The treatment advised was atropine, which, in order to avoid any depressing effects, might be combined with strychnine; or belladonna and nux vomica in association with a mineral acid might be ordered. The prognosis is good, at least to this extent, that there is no reason to believe that the sweating is the forerunner of serious nervous disease; it may be that the symptom will continue for some time, but there is a reasonable prospect that sooner or later it will entirely cease. In the case above quoted, in which unilateral sweating followed an accident, this result ensued in the course of a few months.

Incipient General Paralysis.

The patient was an omnibus-driver, aged 45 years. He complained that for some months he had felt his legs inclined to get stiff after sitting for some time, and also that he very readily felt tired. He noticed, too, in driving, that he could not readily pass the reins from one hand to the other. There was a history of syphilis twenty or more years ago, and last year he had had an attack of influenza. Patient's general appearance was that of a robust and vigorous man. His gait showed little or no evidence of disturbance, and the knee-jerks were active. The pupils acted to light, but they were unequal in size. In conversation with the patient it was noticed that he had a peculiar "catch" in his speech. This, he said, was of recent development. "At times," as he put the position, "I can't get the words out." The tongue, on protrusion, displayed some tremor, and when asked to show his teeth there were marked twitching movements of the facial muscles. Dr. Taylor directed particular attention to this last symptom, and said he had no doubt the case was one of commencing general paralysis in which the physical evidences were relatively advanced, with little or no appreciable mental change. Such cases are not very infrequent, and are apt to be overlooked. In them there may be no recognised mental defect for some time. The patient remains much as in the present case until, with little or no warning, he is the subject of an epileptiform seizure, perhaps accompanied with hemiplegia, after which evidences of mental degeneration become conspicuous. Though in the great majority of cases general paralysis results from syphilis, the disease is not benefited by anti-syphilitic treatment. It is, however, to be remembered that there are certain cases of tertiary syphilis which very closely simulate general paralysis. Hence, on the chance that the present instance may be a case of this order, Dr. Taylor advised a course of mercurial inunction, pushed until some tenderness of the gums is produced, and the administration of potassium iodide in doses of 10 to 20 grains thrice daily.

Optic Nerve Atrophy and General Paralysis.

A case of primary optic atrophy raised the question of the possible relationship of this condition to tabes dorsalis (see POLY-

CLINIC, vol. vi. p. 109). These was no ataxia, the knee-jerks were active, and the pupils exhibited normal reactions. Dr. Taylor quoted the experience of Dr. Mott in favour of the suggestion that a certain number of patients, the subjects of optic atrophy, subsequently became general paralytics. He agreed that general paralysis and tabes dorsalis were essentially the same disease, attacking different parts of the nervous system. Optic atrophy may undoubtedly accompany, or even precede tabes dorsalis. If the above view is correct, it is hardly surprising to find it may also precede general paralysis.

Infantile Paralysis and Infantile Hemiplegia.

A case of each of these was demonstrated, and the contrast between the two conditions pointed out—in one the flaccid, wasted muscles, and absent knee-jerks; in the other the spastic rigidity and exaggerated tendon phenomena. Dr. Taylor said there were some grounds for believing that the cause of the two conditions was the same, and that the pathological lesion underlying them was a thrombosis either in the arteries or the veins.

Other cases included (1) a child with hydrocephalus, and (2) a boy, the subject of pseudo-hypertrophic paralysis.

SURGICAL CASES.

BY J. JACKSON CLARKE, F.R.C.S

Wednesday, June 4, 1902.

Pressure Paraplegia in Spinal Caries. Costo-transversectomy.

WHAT is the best mode of treatment for this condition? *Prolonged rest* is most commonly employed, and not infrequently succeeds. Early *laminectomy* has been advocated as a routine measure. Mr. Clarke doubts the wisdom of this method on *à priori* grounds, and, moreover, he has seen unfavourable results. *Forcible correction of the deformity*, in some cases where paraplegia was present, has resulted in rapid and complete relief; but forcible

correction has dangers of its own, and Mr. Clarke is disinclined to use it if any less dangerous means are at hand. Costo-transversectomy is an operation recommended by Ménard (1894) for this purpose; it consists in the removal of one or more transverse processes and the necks of the corresponding ribs, in order to gain access to the tuberculous matter on the front of the vertebræ. As an illustration of the value of Ménard's proceeding, Mr. Clarke showed a girl, aged 5 years, who had disease of the dorsal vertebræ, the fourth dorsal spine being the most prominent. A radiograph showed a disc of shadow opposite the affected part. This patient was admitted to the North-West London Hospital in May, 1901. She had then complete motor paraplegia of six months' standing. After seven months of complete rest there was no improvement, so on January 16, 1902, Mr. Clarke performed costo-transversectomy, and removed caseous matter from the front of the spine by a Volckmann's spoon. The next day there was evidence of return of motor power in the legs, but this improvement disappeared during the following week. On February 6, the cavity was again scraped, and on the following day return of motor power was noted once more. This time the improvement was maintained and has steadily increased, so that the child is now able to walk again. The general health and spirits of the patient have improved *pari passu*. Mr. Clarke thought that in this operation we had a valuable new way of helping persons with this grave affection. Not only has the paraplegia been cured, but the deformity has been removed by the rest and the method of splinting. He believes this is the first case of the kind published in England.

DISEASES OF THE EYE.

BY ERNEST CLARKE, M.D., F.R.C.S.

Friday, May 30, 1902.

Parenchymatous or Interstitial Keratitis in an Adult.

THE patient, a woman of 45 years, had for four months suffered from a severe affection of the left cornea, and more recently the right

cornea had begun to be affected. In the left eye the cornea was vascularised throughout its whole substance and presented an opaque salmon-coloured appearance. Towards the centre there was a slightly-projecting dull-yellow area, indicating the formation at this spot of a small abscess. In the right cornea there was commencing infiltration at the nasal side of the periphery. The question of main clinical interest was whether or not the condition was due to inherited syphilis. The age of the patient certainly did not support such a diagnosis, but on the other hand it did not absolutely exclude it, for whilst it is true that interstitial keratitis, the result of inherited specific disease, is usually seen in children and young adults, there are exceptional cases in which the appearance of the corneal affection is long postponed. Again, it must be admitted that specific keratitis does not as a rule lead to corneal abscess. There are, however, occasional exceptions, and this case, therefore, may be one of them. The only positive evidence in support of the diagnosis—apart from the affection of the eyes—was the condition of the upper central incisor teeth. Speaking generally, these were well formed. But they were separated by a considerable interval, and each on its cutting edge presented a somewhat notched appearance—not, perhaps, characteristic, but certainly suggestive. The patient always had good health until four months ago, when her eyes began to trouble her. There was not the slightest reason to believe that she had ever had acquired syphilis. Mr. Ernest Clarke concluded that the question of diagnosis must be left without any very definite answer. The age of the patient, the tendency to abscess-formation, and the absence of evidence of syphilis from other tissues, might reasonably be urged against the diagnosis of inherited disease, and it is perhaps too ready an escape from diagnostic difficulties to conclude that interstitial keratitis must needs be syphilitic. On the contrary, there is the certainty that the affection is syphilitic in the great majority of cases, that it is sometimes delayed until adult or middle life, and that the particular teeth which are specially liable to betray evidences of inherited syphilis are in the present case by no means beyond suspicion. Another aspect of the case was its resistance to treatment. Mercury, potassium iodide, cod-liver oil, and other tonics, with sea-air, had all been tried, and tried in vain. Of course, atropine and hot fomentations had been perseveringly used, and leeches had been applied to the temple.

Other Affections of the Cornea.

In addition to the above, Mr. Ernest Clarke showed a number of cases illustrating affections of the cornea. These included examples of interstitial keratitis, various forms of ulcer, of corneal opacity, and superficial keratitis. He also demonstrated several cases of cyclitis, in some of which the deposit on the deep surface of the cornea known as *keratitis punctata* was observed. Mr. Clarke discussed the treatment of these various conditions, and spoke more particularly of the value of the actual cautery in certain varieties of ulcer of the cornea.

CASES WITH COMMENTS FROM THE SURGICAL
CLINIC.

BY MR. HUTCHINSON.

Ununited Fracture of the Clavicle.

INSTANCES of non-union of fractures of the collar-bone are rare. My memory does not record more than a single example of it prior to the one which we had before us a few weeks ago, through the kindness of Dr. Travers Smith. The subject of that case was a labouring man of good development, and apparently in sound health. The fracture had occurred many years ago, and the ends of the broken bone were now smoothly rounded. The outer fragment was an inch at least below the level of the outer end of the inner one. We could not appreciate any bond of union between them, but no doubt they were connected by a thin ligament, perhaps little better than a membrane. The shoulder, and with it the outer fragment, could be moved with the utmost freedom, so that the end of the latter could be almost put into apposition with the inner one. Our first enquiry was as to the amount of disability which the condition entailed, and to this the patient's clear answer was, "None at all." The man was accustomed to hard work, and to carrying burdens on his shoulder, and he averred that he could do everything that he wished to do with ease. You will see that it was his left

shoulder girdle which was involved. We put him through various movements, and though I fear we were not very systematic, yet I think I may say that none of us detected any material awkwardness. It was clear that the shoulder muscles could fix the scapula well, so as to enable the head of the humerus to accomplish almost its full range of movements at the joint. In like manner the inner fragment afforded a fixed point for the sterno-cleido-mastoid. The fracture was near the middle of the bone. Probably it was a transverse one, and hence the failure to unite. The more oblique the fracture of a bone is, obviously the less is the risk of such separation as shall cause non-union. Now most fractures of the clavicle are very



Ununited fracture of the left clavicle, showing depression of the outer fragment. Dr. Travers Smith's case. (From photograph by Burgess.)

oblique, and almost invariably, whatever be the treatment or the neglect of treatment, they unite. The risk is of clumsy union with riding and displacement, not of non-union. Next we asked the man as to the cause of the fracture and the treatment which was adopted. It occurred in a severe fall, which, from other injuries, necessitated his confinement to bed for several weeks. During that time he had no bandage applied, and he was allowed to move about somewhat. Now there is no better treatment for fractured clavicle than confinement to bed on the back. In that position the upper extremity, the weight of which, when erect, always drags down the oute-

fragment, does not come into play, and the two fragments fall into position of themselves, all the muscles remaining quiet. If you have to treat a fractured clavicle in a young lady to whom a smooth collar-bone may be a matter of importance, you cannot do better than try the recumbent position without bandage. But the position must be absolutely dorsal, and must be rigidly observed for a fortnight or three weeks. No sitting up for any purpose must be admitted. The mistake in this case was allowing the man to change his position, and even to sit up; but in reference to this, before we attach blame, we must remember that we do not know the complications which may have been present.

The case may suggest a question as to what is the use of the clavicle in the biped skeleton. Bear in mind that the clavicle here is not absent, it has simply lost continuity in its middle. Its two fragments still serve their purposes for attachments of muscles, but the service of the bone as a prop outwards for the shoulder is lost. Now we have long been aware that unreduced dislocations upwards of the acromial end of the bone, which are fairly common, involve no disablement which the patient recognises. In this instance, however, the prop-service of the bone is much more definitely lost. I can conceive that were our patient a sportsman he would experience much inconvenience in using his left hand to bring his gun into position. And so also of all similar manœuvres. For other purposes, lifting, pulling, carrying weights, &c., it would appear that continuity of the bone is of no great consequence. It used, I believe, to be held that the clavicles were of advantage in hugging. Bell, in his Bridgewater treatise, seems to think so. Undoubtedly, by keeping the shoulders apart they would enable their possessor to clasp a larger armful; but it is possible that, so far from assisting in tightness of grip, they would rather hinder it.

If we turn for help to comparative anatomy we shall not get much. The clavicle in mammalia is a remarkably variable bone. In some orders it is absent, in some it exists only as a short, small bone placed between the sternum and scapula, but connected with them only by long ligaments; in others it is a long, slender, splint-like bone. It is always in relation with the use made of the upper extremity for climbing, grasping, and handling things. In animals in which the forelimb is used simply for progression it is usually

either absent or rudimentary. It is imperfect in all carnivora, but much longer in the cat tribe than any other branch of it. Whilst it is in man the first bone to ossify, in the guinea-pig it is not even present at birth, but appears subsequently. Contrary to what might, perhaps, have been expected, and to what is implied in Sir Charles Bell's treatise, to which I have alluded, it is absent in the bear tribe.¹ The "ant-bear" to which Bell specially refers as a forcible hugger is not a bear but an ant-eater, and has only rudimentary clavicles. It is possible, as I have just suggested, that the presence of clavicles propping the shoulders apart may diminish instead of increasing the animal's power of giving a fatal hug.

A distinguished author has written: "The great importance of the clavicle in the motions of the upper extremity is rendered abundantly evident by observing how completely synchronous are its movements with the slightest change of position of the arm." Similar reasoning might be held to prove that a man's hat is of great importance to the movements of his head. Nor, as a matter of fact, are the movements of the clavicle necessarily synchronous with all those of the arm, but of those only in which the shoulder takes part. Now the clavicle is part of the shoulder.

On the Disuse of Splints in Colles' Fracture.

(Case under the care of Dr. Aitkin.)

I have for many years advocated the treatment of all ordinary forms of fracture of the lower end of the radius without splints of any kind. During the latter half of my tenure of office as surgeon to the London Hospital I never used them, and I am sure that I got much better results than I did during the first half, when I took a great deal of trouble with them. With the exception of certain rare cases, in which the fragments are loose and can be easily pulled into position, and as easily slip out again, nothing more should be done than to place the limb on a thick, firm cushion, and cover the

¹ "When the bear stands up we perceive, from his ungainly attitude and the motion of his paws, that there must be a wide difference in the bones of his upper extremity from those of the ruminant and solipede. He can take the keeper's hat from his head and hold it; he can hug an animal to death. These actions and the power of climbing result from the structure of the shoulder, or from possessing a clavicle, however imperfect." ("Bridgewater Treatise," p. 48.) But bears are proverbially huggers, and they have none.

part with lint wet in an evaporating lotion. These fractures are almost always impacted, or, what comes to the same thing, the fragments are locked together. You cannot move the carpal fragment, and, if you could, it would still be bad practice to attempt it. It was an unfortunate day when Mr. Colles made the discovery that what had formerly been considered badly sprained or partially dislocated wrists were really fractures. Far better treat them as sprains. Many have been the stiffened hands which have resulted from the painstaking use of splints since Colles' day, and many the hours of human ingenuity which have been wasted in devising those splints. The late Dr. Gordon, of Belfast, a most amiable man and excellent surgeon, was the inventor of one of the least hurtful of these: it was an adaptable one. Dr. Gordon was once with me at the London Hospital, and amongst other subjects we spoke of this. He regretted that London surgeons had not more generally adopted his splint, and pathetically remarked: "The only man among you who praises it is Mr. Z., and he uses it wrong end upwards."

A few weeks ago Dr. Aitkin brought for our inspection a quite recent fracture of this kind. It was in an elderly woman, who had fallen on her hands. All the usual features were present: the thickening of the wrist, the projection of the styloid process of the ulna, and the general swelling of the parts. I believe that Dr. Aitkin's object in bringing us the case was that I might advise as to the best splint, and explain the best method of reduction. He was, I think, a little surprised when I counselled him not to attempt reduction and not to use any splint. We made it evident that the broken fragments were firmly locked together by encouraging the patient to lift her hand, and by gently effecting pronation and supination without causing her pain. Three weeks later Dr. Aitkin was good enough to bring his patient again. He had carried out my plan, and both he and his patient were much pleased with the result. There was the usual deformity and thickening, but that was all. The swelling was gone, neither the wrist nor the fingers were stiff, and the patient could lift her hand about with ease. It was in all respects in far better condition than I ever saw one at the time of laying aside the splints. The degree of displacement of the carpal fragments varies much in different cases, and in many it is very

slight. With the very rarest exceptions you can neither pull nor press them into place. Their displacement is effected at the moment of the fall, and it is irrevocable. It is not due to muscular action. If you attempt to replace them by pressure, curves in your splint, pads here or pads there, twists of the hand, &c., all that you will do is to jam the tendons against the projecting bones and thus cause them to become glued to their sheaths. So strong, however, is the popular and even professional prejudice against treating fractures without "setting" them, that should you incline to adopt my plan you must most carefully explain matters to your patient. Let it be well understood that you know that the bone is broken, and that you abstain from setting it and putting it in splints on principle; that a certain amount of deformity is inevitable, and that the effect of splints would be only to produce stiffening in addition.

Alopecia Areata Twelve Years after Ringworm.

On May 8, we had before us a case of typical alopecia areata in a woman, aged 24. The history was that at the age of 12 she had attended at Great Ormond Street for ringworm.

Cancer of Both Breasts, with Remarkable Erythematous implication of the Skin over the whole of One Side of Chest, both back and front.

(Case under the care of Dr. Tom Robinson.)

A week or two after we had seen the case of cancer of both breasts, which is recorded at p. 311, another example of this bilateral affection was brought to us by Dr. Tom Robinson. The conditions were, however, very dissimilar, and were such as to put the question of operation quite aside. Not only were there large growths in both breasts, but the whole of one side of the thorax, (the right) was involved in florid erythema, with small, scattered nodules of new growth. The florid condition of skin was so vivid and apparently so superficial that it might have been taken for a temporary condition due to some accidental cause. It involved literally the whole chest, extending on the back as far as the spines of the vertebræ and there ending abruptly. On careful inspection it

was seen that the dilated vessels were arranged more or less in tufts and streaks, and here and there the affected skin was slightly hardened. The tumour of the breast on this side adhered to the skin, and over a large area around it were little nodules, about which there could be no mistake. Without doubt we had before us an example of diffuse infiltration of the integument, the early stage of what has been called *scirrhus encuirasse*. By-and-by, and probably at an early period, the whole side of the chest will be cased in a dense, leather-like investment. It is an interesting question as to whether the cancerous cell material spreads in the perivascular spaces or the lymph-spaces. Probably it is in the latter, and the remarkable implication of the vessels is secondary. Sometimes we see a congestion which is chiefly venous, and sometimes the tint is a deep plum-colour. It is seldom that we see the skin so florid and so much like erysipelas as it was in this instance. This kind of implication of skin must, of course, be taken as indicating great activity of growth on the part of the cancer tissue.

Dr. Robinson's patient was a stout woman, not much past middle age, and she had not materially failed in health. The disease had been first recognised in the right breast, and only about eighteen months ago.

REVIEWS AND NOTICES OF BOOKS.

THE NEW VOLUMES OF THE ENCYCLOPÆDIA BRITANNICA.

Two volumes of this magnificent Supplement to a world-renowned work are already in the hands of the subscribers. We cannot too highly commend them to the attention of our profession. They ought to be in the library of every medical man who can afford them. Some of the articles on medical subjects are lengthy, and from the pens of high authorities. That on bacteriology is admirable. The botanical part is by Marshall Ward, and the pathological by Dr. Muir. The article on cancer, by Dr. Arthur Shadwell, brings our knowledge both of statistics and pathology well up to the present date. We have quoted from it at page 319, and shall have to do so again and again in the future.

THE RÖNTGEN RAYS IN MEDICINE AND SURGERY AS AN AID TO DIAGNOSIS AND AS A THERAPEUTIC AGENT DESIGNED FOR THE USE OF PRACTITIONERS AND STUDENTS. By Francis H. Williams, M.D.Harv. The Macmillan Company. Price 25s.

THIS work brings our knowledge of the Röntgen rays as applicable to the diagnosis and treatment of disease up to the latest date, and will be acceptable to a large class of readers. In all that regards technique it is clear, explicit, and full, and it abounds in well-devised illustrations: of the latter there are nearly 400. It is impossible to attempt any analysis of it, and quotations would be useless. We can only give it our warm commendation as by far the best guide obtainable to a sound knowledge of the subject on which it treats.

CATALOGUE-COMPANION TO THE MUSEUM.

(Continued from page 267.)

WE continue our description of the portraits which illustrate tubercular affections of the skin, comprising chiefly those classed under the head of Lupus on the hands and feet. This disease assumes certain peculiarities, and we have therefore placed them in a separate group.

Lupus Vulgaris affecting Hands and Feet.

Our collection comprises more than twenty portraits illustrating the conditions displayed by lupus when the extremities are affected. In many of these, other parts were involved at the same time, thus affording confirmation of the diagnosis. Owing probably to the special conditions as regards circulation and the influence of cold, lupus of the hands but seldom assumes features closely resembling the disease when seen on other parts. We never see the apple-jelly granuloma-substance, and dry exfoliative patches are also infrequent. There is a proneness on the one hand to inflammation attended with swelling, and on the other to outgrowth of papillæ. Not unfrequently the conditions change with the season, and a patch which in summer is

dry and rough may be concealed under a pus crust in winter. Much, also, will depend upon the vocation of the patient, and whether the hands have been protected against exposure or otherwise. It may be supposed probable that in many cases of lupus of the hands direct inoculation has preceded the disease. This is the probable explanation of most cases in which the hands of those engaged in dissecting or making post mortems become affected, and which are often named *Lupus necrogenicus*. On the other hand, it is possible that even in these cases there is no implantation of virus, but only an irritative injury in a susceptible, *i.e.*, tuberculous subject. No line of abrupt separation can be drawn between necrogenic lupus and other forms. The terms used by different authors, in describing their portraits, sufficiently illustrate and confirm what we have said. The names "*Lupus papillomatosus*," "*Lupus verrucosus*," "*Tuberculosis verrucosa cutis*," "*Lupus ulcerosus hypertrophicus*," and the adjectives "*fungosus*" and "*exulcerosus*," are all descriptive, not of different types of Lupus, but of peculiarities assumed in connection with the part affected.

Mounted together in a swing frame we have the following seven illustrations of *lupus vulgaris* on the back of the hand :—

No. 35 (*Crocker's Atlas*) is fig. 4 of one of the plates in Radcliffe Crocker's *Atlas*, and is designated *lupus verrucosus*. It shows a streak of apparently hard papillary growth on the back of the radial border of the wrist, and four other similar ones on the backs of the fingers. There is evidence of another patch on the under border of the palm, and there is a scar of apparently *lupus vulgaris* higher up on the forearm. This portrait is remarkable on account of the absence of inflammation of the adjacent tissues. It is highly probable that it was taken during hot weather, and from a patient who had been able to give his hand good protection.

No. 36 K.—T. 343. This portrait shows a large crusted papillomatous patch on the radial border of the wrist and hand. It is from Kaposi's *Atlas*, with the designation *Tuberculosis verrucosa cutis*.—(*Riehl und Paltauf*.)

No. 37. From Crocker's *Atlas*, and diagnosed as *Verruca necrogenica*. It shows large, crusted, and somewhat inflamed patches across the big hand of an adult man.

No. 38. From Hebra's Atlas. Shows conditions very similar to the preceding in detached patches on the back of the hand and fingers.

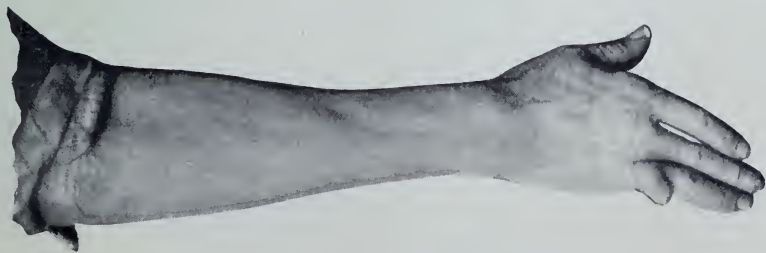
No. 39. This portrait, also from Hebra's Atlas, shows a large scar on the back of the hand, and crusted lupus patches around its edge and on the backs of the fingers, probably from an elderly man, and one whose hand had been exposed to cold, &c.

No. 40. The palm of the hand of the same patient, showing lupus patches over almost the whole surface. This is perhaps the only portrait which we possess showing lupus of the palm.

No. 41. Fig. 3, in one of Crocker's plates, shows a crusted patch with a scar in the middle, occupying the whole of the back of the hand of a young person. It is denominated "Lupus papillomatosus," but the sketch does not show anything different from the ordinary conditions of inflamed lupus.

No. 42. Fig. 2 of one of Crocker's plates exhibits two patches which have joined across the knuckles of a child. The edges are somewhat inflamed and the surface covered with crust. It is named "Lupus verrucosus," but nothing is shown which would seem to require the adjective.

Nos. 43 and 44. Two photographs from the same patient—a man under the observation of Dr. Crossley Wright, of Halifax. He had scars of lupus on the backs of both hands and in some other parts. On one hand considerable contraction had followed the healing of the lupus. On the other, epithelial cancer, attended by free papillomatous growth, finally occurred, and amputation became necessary (see appended illustrations).



No. 43.—Scar on the back of the hand after Lupus, with contraction of the little finger.
(Dr. Crossley Wright's case.)



No. 44.—*Epithelial Cancer developed in the scar of Lupus on the back of the hand and forearm. The patient had other scars of Lupus. (Dr. Crossley Wright's case.)*

No. 45 (*original*) is a coloured drawing showing an ulcer of a very peculiar character, but probably lupus, on the back of the hand of an old man. Its peculiarities consisted in its rounded form and the thick bossy rim which surrounded it. This border was smooth on its outer aspect, but much undermined on its inner one. There was a tendency to heal in the centre. There were no papillary growths. The ulcer had been present several years,



No. 45.—*An exceptional form of Lupus (?) on the back of the hand of an old man. (Original, J. H.)*

and the old man died a few years after the portrait was taken, without having been cured. The progress of the disease was more like that of a tubercular affection than a malignant one. The Museum possesses another portrait which shows a form of ulceration almost exactly like that now described. In it, also, the patient was an old man, and the ulcer continued to slowly extend for several years. A series of illustrations exhibit it at different stages. The man was an inmate of St. Pancras Workhouse.

Cases of Lupus in which the Mucous Membranes were involved.

When the mucous membranes are involved the type of lupus is almost always that known as vulgaris. In a very large majority the process has begun on the skin and has attacked the mucous membrane by extension in continuity. In a certain number, however, the mucous membranes, cheeks, palate, pharynx, &c., are affected at the same time as the skin, but in patches which are quite separate from each other. In a still smaller number the mucous membranes are attacked first, and without any accompanying disease in the skin. The most common extension is to the lining membrane of the nostrils, since the commonest site for lupus vulgaris is the nose. Next in frequency come the lips and gums, and next to them the palate, pharynx, and larynx. Extension to the conjunctiva is not common, and when it occurs it may be in entire discontinuity with the cheeks. In a few very troublesome cases the disease may extend to, or have begun in, the lachrymal sac. The following descriptions comprise the principal portraits in our collection which illustrate cases in which any part of the mucous surfaces was involved.

No. 46 (from *Crocker's Atlas*). The full face of a girl in whom the alæ nasi and end of nose have been destroyed, and large patches of lupus extend almost symmetrically over the cheeks, lips and chin. Some initial spots are seen in group on the upper eyelid of the right eye.

This portrait is designated "Lupus vulgaris (scrofulosorum)." It is an excellent illustration of a common type of lupus vulgaris—that which begins on the nose and extends symmetrically over both cheeks. The epithet "*scrofulosorum*" is surely superfluous, since it is almost equally applicable to all lupus vulgaris.

(To be continued.)

CORRESPONDENCE AND ANSWERS.

MISS BIRD ON MOLOKAI.—“Yet Molokai is only enchanting in the distance, for its blue petals enfold 400 lepers doomed to endless isolation, and 300 more are shortly to be weeded out and sent thither. In to-day's paper appeared the painful notice, ‘All lepers are required to report themselves to the Government Health Officer within fourteen days from this date for inspection and final banishment to Molokai.’ It is hoped that leprosy may be ‘stamped out’ by these stringent measures, but the leprous taint must be strong in many families, and the social gregarious natives smoke each other's pipes and wear each other's clothes, and either from fatalism or ignorance have disregarded all precautions regarding this woful disease; and now that measures are being taken for the isolation of lepers, they are concealing them under mats and in caves and woods. This forlorn malady, called here Chinese leprosy, in the cases that I have seen confers nothing of the white scaly look attributed to Syrian leprosy; but the face is red, puffed, bloated and shining and the eyes glazed, and I am told that in its advanced stage the swollen limbs decay and drop off. It is a fresh item of the infinite curse which has come upon this race, and with Molokai in sight the Hesperides vanished, and I ceased to believe that the Fortunate Islands exist here or elsewhere on this weary earth.”—(“Hawaii,” p. 166. By Miss Bird.)

“Between 1866 and April, 1874, 1,145 lepers, 560 of whom were sent from Kahili in the spring of 1872, have arrived on Molokai, of which number 442 have died—the majority of the deaths having occurred since the beginning of Lunalilo's reign when the work of segregation was undertaken in earnest. At the present time the number on the island is 703, including 22 children. These unfortunates are necessarily pauperized, and the small Hawaiian kingdom finds itself much burdened by their support.”—(“Hawaii,” p. 294. By Miss Bird.)

“Each leper receives weekly 21 lbs. of païdi, and from 5 to 6 lbs. of beef, and when these fail to be landed 9 lbs. of rice, 1 lb. of sugar and 4 lbs. of salmon.”—(p. 297.)

“In another room was one—a mass of rotting flesh, with but little semblance of humanity remaining—who was dying, and whose breath came hurried and obstructed. A few hours at most and his troubles would be over and his happy release arrive. There had been fourteen deaths in the settlement during the previous fortnight. On the day of our visit there were fifty-eight inmates of the hospital.”—(p. 300.)

* * *

DIMINUTION OF TUBERCULOSIS IN ADULTS AND INCREASE IN CHILDREN.—Sir T. Thorne has pointed out that whilst since 1850 the mortality of adults from phthisis had diminished 45 per cent., the infantile mortality from tuberculosis had increased 27 per cent. There may be sources of fallacy in these estimates.

* * *

THE CURABILITY OF PULMONARY PHTHISIS.—M. Brouardel stated, as the result of his experiences at the Morgue in Paris on the bodies of those who had met with deaths from accident, that of adults who had lived ten years in Paris one-half showed healed tuberculous lesions. Many of them were those of advanced phthisis. He pointed out that these persons had recovered from phthisis without special treatment, often in spite of having remained under very unsuitable conditions. He added emphatically, “Phthisis, then, is curable, even in its most advanced stages.”



My very affectionate son
Thomas Hodgkin

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. VI., No. 8.—AUGUST, 1902.

DR. THOMAS HODGKIN.

THE New Sydenham Society, which had previously, in its Pathological Atlas, given a series of interesting original drawings in illustration of Hodgkin's Disease, very appropriately followed up the subject by reprinting the original Essay in which it was described. This essay will be found in vol. clxxiii. of the Society's Library, and with it was given a brief biography with a portrait of the very distinguished clinical pathologist who was its author. This portrait we have now, by the courtesy of the Society's Council, the pleasure of offering to the readers of the Polyclinic.

Dr. Thomas Hodgkin was born in 1798. He practised in London and was for many years connected with Guy's Hospital in the capacity of pathologist. He had hoped to be appointed on the Medical staff, but having given umbrage to some who were then in power by his zealous exertions in the cause of aboriginal races, his claims, which the profession of the day regarded as paramount, were very unjustly passed over. This failure to secure position he felt keenly, but although it did probably tend to turn his work more in the direction of anthropological and philanthropic pursuits, it did not by any means extinguish his zeal for medicine. He published in 1841 some Lectures on Health, having previously, in 1836, published

others on the Pathology of the Serous and Mucous Membranes. It was he who suggested to Mr. Christie the collection of the Ethnological museum which for long bore his name and was ultimately transferred to South Kensington. In some sense Dr. Hodgkin may be esteemed as a fore-runner of the Post Graduate schemes of the present day, for he was accustomed to give lectures on pathology in his own drawing-room in Bedford Square to the practitioners of the neighbourhood. He was repeatedly President of the Geographical Society, and one of the Founders of the Ethnographical.

The paper on what is now known as Hodgkin's Disease was published in 1832, in the *Medico-Chirurgical Transactions*.

The generation of the Guy's staff, which is now represented almost solely by Mr. John Birkett and Sir Samuel Wilks, had many quaint stories to relate of Dr. Hodgkin. He was by birth a quaker and he retained to the last the peculiarities of dress and speech which used to distinguish that body. With these there went a straightforward simplicity of purpose and directness of diction which occasionally raised a smile. Sir Astley Cooper is said to have told him on one occasion that broad as were his hat-brims they were not wide enough to cover his large heart.

In the later part of his life in company with his patient and friend, Sir Moses Montefiore, Dr. Hodgkin visited Morocco and Palestine, the object of the pilgrimages being to ameliorate the condition of the poor Jews residing there. It was during the second of these missions that he was attacked with fever at Jaffa. He died there on April 5, 1866, at the age of 68.

The autograph which we have appended to his portrait has been kindly supplied to us by his nephew Dr. Thomas Hodgkin, of Barmoor Castle, the distinguished author of the *History of the Renaissance in Italy*. It was written at the age of 41. It is taken from a letter to the writer's father, under date, "8th month, 17, 1839," in which the following expressions immediately precede the signature:—"I am not forgetful that I this day complete my 41st year, and I cannot but sensibly feel how much cause I have to desire that the remaining years which I may be permitted to enjoy with my friends may be more fully devoted to the real purpose of life."

STATISTICS OF CANCER IN THE FRIENDS' PROVIDENT INSTITUTION.

WE mentioned last month that the statistics of death in the Friends' Provident Institution did not reveal any increase in the ratio of cancer deaths to others during the last twenty years. Further investigations have placed us in a position to carry the statement still further back, and to say that there has been no increase during the last half century.

During the decennium 1851 to 1860, with a total of deaths of men 232, and women 125, the percentage of deaths from cancer was $3\frac{1}{2}$ for men and 5 for women. This is almost exactly the same as that of the last ten years.

As the full facts as to the cases registered as "Cancer" during this period at this Institution have been placed in our hands, it may be of interest to bring before our readers a brief analysis of them. The total number amounts to ninety-four, of which sixty-seven were men, and twenty-seven were women.

The average age at death of the whole was for men 62·3, for women 65·8. It must be remembered in this connection that comparatively few women insure their lives, and further, that of those who do so the majority are probably either widows or spinsters and that the insurances are effected at a later date in life than with men. It would appear further that there is some reluctance on the part of the certifier to specify the organ affected in women. In sixteen instances out of the total there is no mention of it, the death being registered simply as from "cancer"; out of this sixteen no fewer than fourteen were women whilst only two were men. This omission of course invalidates the statements as to the special organs in women. Only three are recorded as having died of cancer of the uterus, and only two from cancer of the breast. Since the total number of women is only twenty-four and we have thus taken out fourteen, it follows that in the following statements as to the organ affected we are dealing almost exclusively with men.

As to the organ affected the Liver heads the list with sixteen

cases, next comes the Rectum with thirteen, and next to it the Stomach and Pylorus with twelve.

Cancer of the Tongue and mouth was registered in ten cases, of which in six the tongue was the part affected, the pharynx twice, the larynx and tonsil, in each once.

In four instances the Bladder was the part affected, in three the Œsophagus, in one the Omentum, in one the Penis, and in one the Thyroid gland. In six instances some part of the intestinal tract other than those we have specially mentioned was the seat of the disease, all the patients being men. In two cases the Pancreas was the seat of the disease, both men, and both aged 53. In one case, that of a man, aged 74, the disease was registered as "cancer of face and left side of head," probably rodent, and in another, a woman, aged 50, the register was "carcinoma of the head, cerebral cachæxia and exhaustion."

The average age at death is so nearly the same for all the organs concerning which the numbers are sufficient to justify the striking of any average at all that it is scarcely worth while to mention them separately. It varies from 61 to 65, being in the majority 63. In the case of the tongue it is only 51, and here we no doubt have represented the smoker's early risk. All the cases, ten in number, in which the tongue or pharynx was affected occurred in men; and the same statement, with one exception, applies to thirteen cases of cancer of the rectum. The youngest in the list is a man named T. A., who died aged 24, in 1888, of cancer of the stomach; next to him comes G. C., who died at the age of 39, of cancer of the tongue, in 1897; G. E. T., who died, aged 43, in 1886, of cancer of the liver and disease of the heart; next G. H. M., who died, aged 45, of cancer of the rectum.

It would be of great interest if other Insurance Offices would supply similar materials, and enable us to judge whether this one is peculiar in its experience. Care should be taken to give the form of disease named in the certificate, as well as the sex and age of the person concerned.

NEW ZEALAND CANCER-STATISTICS.

THE statistics of cancer in New Zealand present the peculiar feature that those of males exceed in number those of females. During the five years 1896-1900 there died a total of 1,195 men and only 958 women.

In nearly 31 per cent. of the deaths from cancer in males the mouth, lip, tongue, or throat was the part affected. Here we clearly have the influence of smoking, for in women these parts were affected in only 6 per cent. The stomach takes 34 per cent. in males and 20 per cent. in females. Unexpectedly, cancer of the stomach appears to be commoner in women than cancer of the breast, the breast having only 12 per cent. of deaths against 20 per cent. of the stomach. Intestines and rectum are nearly equal in the two sexes, being nearly 11 per cent. Liver—men, 15 per cent. ; women, 15 per cent. As might be anticipated, many more men than women die of cancer of the kidneys, bladder, &c. The numbers are 54 males and 15 females.

The increase of cancer in New Zealand during the last decade has been closely parallel to that which has occurred in the United Kingdom. It has been very considerable, and chiefly in the male sex. In 1891, 154 males died of cancer; in each successive year the number increased until in 1900 it had reached 246. In women during the same period the increase was from 141 to 184. The explanation of this most unusual excess in males is afforded chiefly by the large number of cases of cancer of the mouth. It is hardly credible, but the figures appear to show that the total of cases of cancer of the mouth in men almost equals that of cancer of the breast, uterus, ovary, and vagina in women all added together. This is a very heavy accusation against New Zealand tobacco. Does it contain arsenic? Do New Zealanders chew, or do they swallow their smoke? The numbers are 336 cases of smokers' cancer against 354 of all the female organs specified. If we might venture to place 74 cases of cancer of the stomach as possibly due to the same cause, and as being the excess in males over females as regards that organ, the lesson is still more strongly enforced. Men in New Zealand from the habit of smoking actually encounter

a greater risk of cancer than is incident to women from the possession of organs specially prone to it.

These proportions are very different from those of England. Dr. Tatham's tables show under the headings "Lip, Mouth, Tongue, Throat, and Œsophagus" a total (in men) of 6,528, whilst under the heading "Generative and Mammary Organs in Women" we have the enormous total of 25,157. The question arises, of course, is this discrepancy due to the small number of cases in the female organs in New Zealand and the very large number in England, or to an excessive number of mouth cases in New Zealand as compared with England?

The deaths from cancer per 10,000 of the population were of both sexes 4.68 in 1891. In 1900 these ratios had increased to 5.6 and 5.9 respectively.

If we contrast these ratios with those afforded by the Society of Friends in England, we shall find them almost exactly the same, but then in New Zealand they are calculated on all ages, and in the other case only on those who had attained an age sufficient to make it worth while to insure their lives. This makes it evident that New Zealanders suffer far more from cancer than do members of the Society of Friends in England.

New Zealand gets the bulk of its tobacco (chiefly in a manufactured state), from the United States. It imported in 1900, 1,704,403 lbs. In addition to this it received from various sources in the form of cigars and cigarettes 249,529 lbs., and 1,853 lbs. of snuff.

If we deduct as for re-exportation 100,000 lbs., we find that this allows for the male population (roundly 406,000) nearly 4 lbs. a head. This includes infants and children, but does not take count of a certain number of female smokers, nor of the Maories. The Maori population is perhaps one nineteenth of the whole. In New Zealand, both amongst Europeans and Maories, males are in excess of females (in the proportion of 40 to 36, and 20 to 23 respectively). Each year witnesses a diminution of this difference.

The total number of Cancer patients admitted into the various Hospitals of New Zealand during 1900, was 316, and of these 86 died in the institutions. The figures are almost exactly the same for Phthisis. The deaths from Phthisis in the same places during

the same year were : Auckland, 45 ; Dunedin, 25 ; Christchurch, 35 ; Wellington, 44. From Cancer : Auckland, 58 ; Dunedin, 52 ; Christchurch, 23 ; Wellington, 39.

MEDICINAL USE OF ARSENIC.

IF we may take a case which is reported in the last number of the *Cleveland Medical Journal* as representative, it would appear probable that arsenic is used quite as boldly in the States as in England.¹ A girl of sixteen, out of health, suffering from severe chorea, was admitted into a hospital at Columbus under the care of Dr. D. N. Kinsman. Fowler's solution in five-drop doses was prescribed, and was gradually increased until, three weeks later, she was taking thirty-six drops a day. At this time, ten drops of the tincture of iron were added and the arsenic continued. An eruption appeared on the chin, and for a week the arsenic was suspended. A week later, the arsenic was resumed in one-drop doses every hour. A fortnight later vomiting and diarrhoea set in, and under Dr. Kinsman's advice, who now for the first time saw the case, the arsenic was finally put aside. The chorea was now well, but all the extremities were paralysed. The loss of muscular power did not extend higher than the elbows and knees, and appeared to be distinctly peripheral in origin. The muscles were wasted and the deep reflexes lost. The sphincters were intact, and sensation (in all forms) was not interfered with. There was no tenderness over nerve-trunks.

Dr. Kinsman calculates that an average of twenty-three drops, or a little more than a fifth of a grain, had been taken daily for thirty-six days, and adds, "The dosage in this case was not extraordinary." He quotes the case of a woman with pernicious anæmia, who took ninety drops a day for four weeks without ill consequences. He suggests that possibly the addition of the iron made the arsenic more poisonous (synergism). The paralysis in his patient persisted for some months, and would, he feared, be permanent.

¹ Cases closely parallel with this have been published by other physicians. See a case by Dr. Osler, in *Montreal Medical Journal*, April, 1893, and others by Dr. Railton, of Manchester, in *British Medical Journal*. The latter gave fifteen drops three times a day to a girl of 10, but records his conviction that such doses are dangerous if given for more than a week. Dr. John Adams, of Halifax, has also published an instructive case. These papers may all be referred to in the Polyclinic Library in EXTRACT BOOK, "*Arsenic*," pages 23 and 49.

FISH-EATING IN JAPAN.

From a recent author we have the following items of information as to the manner in which fish is eaten uncooked in Japan. Describing the presents offered during visits we are told :—

“A paper packet containing a small piece of dried fish is also frequently presented. Lobsters and oranges are also mutually exchanged, the former as the best fish of the sea, the latter as being the best fruit. The lobsters received in this way are *dried, pounded* and consumed for certain diseases.”

In reference to leprosy we learn :—

“At the time when the whole city migrates to the country the high roads are lined for miles with mendicants of every description, the aged lepers and cripples who have left their ordinary resorts about the precincts of the temples . . . These people form a class of themselves and are in some ways regarded as unclean. Filth and deformity render them often such hideous objects that they inspire more disgust than pity. Many amongst them are blind or have their limbs fearfully enlarged by elephantiasis.”

It is thus clear that in Japan in the present day, as in Europe in the Middle Ages, lepers and other cripples and mendicants mix together, a condition of things which, if leprosy were contagious, would ensure its perpetuation.

 KELOID IN THE DARK RACES.

It is well known that negroes in all countries are very prone to develop the Keloid of scars. We doubt, however, whether there be not some great exaggeration in a statement made by Dr. Kerr Cross, of the Nyassa Mission. Dr. Cross writes: “If a native gets a cut, it becomes like a tumour or a new growth. If he has been vaccinated, the mark rises up like a two-shilling piece. If he tattoos himself, the surface becomes a series of little growths, protruding above the level of the skin.”

During my recent visit to the Cape and Natal, I saw, in connection with leprosy examinations, a great many dark-skinned persons stripped. They were of various races, but chiefly Hottentots or Kaffirs, or of mixed blood. Very many showed the marks of cupping or of scarification, done for medical purposes by their own doctors. The latter, as is well known, are very fond of this method of treat-

ment, and a man's skin, both on arms and trunk, is often seen to be covered with small scars. It is not uncommon to see these little scars slightly indurated, but I have very seldom indeed seen them approach anything which could be counted as keloid; nor did I in any single instance see their vaccination scars in a keloid condition. In only one instance did I meet with well-characterised keloid growths on a Kaffir. This was in the case of an epileptic Kaffir in the Emjanyana Hospital, who was shown to me by Dr. Cassidy. He had frequently fallen into the fire, and had thus received many burns at different times. Masses of keloid had been produced in the resulting scars. In this instance large areas were involved in abruptly margined, thick, bossy growths.

J. H.

HOP-CHEWING AS A POSSIBLE CAUSE OF ARSENICAL POISONING.

IN the interesting paper read by Dr. Reynolds, of Manchester, on the Beer-arsenic epidemic, a case is mentioned in which arsenical poisoning, with pigmentation, was traced to the habit of chewing hops. The patient was a hop merchant. A valued correspondent to whom we are indebted for much information as to German breweries concludes his letter: "Lastly, I may add the following fact. The business of selling hops to brewers has been carried on for years by four of my own brothers. Three of the four are dead and all died, as proved by *post-mortem* examination, of cancer of the stomach. I have three other brothers not in the trade who are all well. There is no previous history of cancer in the family."

The analyses of Hops made for the Royal Commission have shewn that arsenic in small quantity is present in a majority of specimens of English hops. The quantity is too small to constitute a source of danger to the beer, but it might be quite appreciable in its effects upon anyone who had taken to chewing the hops themselves. A hundredth of a grain to a pound of hops was the largest quantity found.

INCREASE IN THE MEDICINAL USE OF ARSENIC.

WE quoted in our July number some very important facts supplied to us by Messrs. Allen & Hanbury as to the increase in the prescribing of arsenic by medical men. They shewed that during 1861 arsenic occurred once in every 81 prescriptions, and in 1901 once in every 14. Mr. Cornelius Hanbury has been good enough since we wrote to carry the investigation further back, and he now reports from the examination of 1700 prescriptions in the years 1834 to 1840 that arsenic occurred only once in every 565; and that in the years 1840-1842, including about 2,000 prescriptions, it occurred only once in every 261. Thus we may apparently assume that sixty years ago a drug which now appears in one out of every twenty prescriptions for private patients was scarcely in use at all. It is a curious coincidence, if it be nothing more, that it is precisely during this interval that the increase in cancer has occurred which has claimed so much attention.

THE EARLIEST RISK OF ARSENICATED BEER.

THE risk of arsenical contamination of beer dates from the introduction of gas and the employment of gas-works coke for the drying of malt. From one of the largest of our London breweries we learn that for a hundred years past they have used coke for this purpose. The first gas works in England were erected in Birmingham in 1798, at Messrs. Boulton & Watts' Soho Foundry. Gas-light was first publicly used at the peace rejoicings of 1802. Its use had become fairly general in London in 1816, and from that date the supply of coke for drying malt may be supposed to have been abundant.

CANCER IN THE UNITED STATES.

WE have been informed by Dr. Hall, of Denver, U.S.A., that one result of cancer investigation in the States has been that the increase has occurred chiefly in men. It has occurred especially in certain river valleys where the population is chiefly German. The Germans drink more beer and smoke more than the Americans. It has been attributed to the water.

LEPROSY IN BIKANEER (SANDY DESERT).

SURGEON PANK, of the Indian Medical Service, who knew leprosy well, gave me interesting information respecting the Sandy Desert country of the North-West. He had resided at Bikaner, and had charge of the Leper Hospital there. Bikaner is in a sandy desert, and was built as a place of safety, having two hundred miles of desert on all sides of it. It has no rivers, and only one small lake, the property of the Rajah. It is a wealthy place, and is considered healthy. It has 50,000 population, of mixed creeds. Dr. Pank at first told me that he thought no fish was eaten there. Certainly, at most times of the year, no fresh fish could be obtained, and he did not know of the importation of salt fish. A remarkable feature is the absence of gardens and of all green vegetables fit for the table. In the dry season nothing green is to be seen. The rains begin in June and continue till September, and the country is soon green over after their commencement. Sheep are kept, and Bikaner wool is famous. I pressed Dr. Pank as to whether the sheep did not imply water, and as to whether, in the rainy season, fish did not rapidly appear. He told me that all the natives believed that fish were rained down from the clouds, so immediate was their appearance after the rain began.

The wealth of Bikaner is derived by distant mercantile trade, and some articles of food are imported.

When Mr. Pank had charge of the leper house, it had only three or four inmates, and the segregation was not compulsory. They went in and out as they liked.

It is therefore clear that leprosy is rare. It is also clear that fish food is not impossible during a certain period of the year.

RHEUMATISM IN NYASSALAND.

Rheumatic fever is reported by Dr. Kerr Cross to be very common in North Nyassaland. That it differs somewhat in its results from the English type of the disease may be inferred from his additional statement: "Many of their joints are affected by this disease." As is well known, it is not usual in England for acute rheumatism to cripple the joints.

POLYCLINIC NOTICE.

ARRANGEMENTS are in progress for a composite course of Lectures on the Practice of Medicine and Surgery, together with their special branches.

The first series of these lectures will be delivered during the months of October, November, and December, 1902.

These lectures will be given at 5.30 on the afternoons of Tuesday and Thursday in each week.

It is designed that the lectures shall be expository of the present state of knowledge on the subjects of which they treat. With the concurrence of the lecturer of the day, opportunity will be afforded for asking questions at the conclusion of each. They will be illustrated from the Museum.

Members of the Polyclinic will be admitted free; to all others the fee for the course will be One Guinea. A limited number of tickets will be reserved for lady practitioners and possibly for fifth-year students. The consideration as to the admission of the latter is still before the Council.

NOTES OF CONVERSATIONS WITH DR. HANSEN.

REPORTED BY JONATHAN HUTCHINSON, F.R.S., ETC.

THE visit of Dr. Hansen to London and his appearances, first at the Royal Medical and Chirurgical Society, and subsequently at the Polyclinic, have constituted an important event to that section of the medical profession which interests itself in the subject upon which he is the leading European authority. His engaging personality, his freedom from prejudice, his exactitude of information and perfect candour, together with his willingness to be interrogated, have secured the admiring approbation of all who met him. It was his first visit to England. As supplementing the record of more formal opportunities, the following notes of conversations with Dr. Hansen may be acceptable to many of our readers.

Asked as to the relationship between tuberculosis and leprosy, Dr. Hansen asserted with emphasis that it was not possible to distinguish the isolated bacillus of the one from the bacillus of the other.

“Do you mean to say that there are no differences in their form or in their staining reactions?”

“Certainly there are none which are trustworthy. The lepra-bacillus stains perhaps more readily than that of tuberculosis, but it is a matter of degree, and those who think that they can establish trustworthy differences are, in my opinion, mistaken. As to form, the tubercle bacillus is sometimes curved whilst the lepra one never is, but this is an inconstant character.”

“The great difference, then, is not in individual bacilli, but in their behaviour in masses?”

“That is it, the lepra bacillus occurs in enormous numbers, whilst you have to seek for those of tubercle, and often find but very few. Those of lepra gather themselves together into clusters and nodules. I used to be able to diagnose leprosy deposits by the microscope before I discovered the bacillus. The brown glomerules are quite characteristic.”

"The tubercle of birds comes, I have been told, more close to the leprosy parasite than does that of mammals."

"I am not familiar with avian tubercle, but I do assure you that I know of no means of distinguishing leprotic bacilli from those of mammalian tuberculosis, unless you take into consideration their numbers and mode of arrangement. I suspect that the bacilli of tuberculosis form their toxin much more abundantly than do those of leprosy. Febrile conditions are much more common in tuberculosis than in leprosy. Some one, you know, has recently found giant cells in leprotic nodules. For my part, I can only say that I have never seen them, and I have certainly examined some thousands of specimens."

"You do not, then, believe in them?"

"I am not entitled to disbelieve, but I have never seen them."

"You have told us that Dr. Lie has recently found bacilli in the spinal cords of patients in whom for long before death all symptoms of the disease had been in abeyance. Do you suppose that the bacilli were living?"

"I know of no means of distinguishing a living from a dead bacillus. You cannot cultivate it, and so you cannot determine as to its being alive or not. It has recently been asserted that the bacilli, as we find them in the skin, are always dead, but I do not know in the least how the man who makes that assertion goes about to prove it. It is certain from Dr. Lie's investigations that the leprosy bacillus may lodge in the tissues quite quietly for long periods of time, but whether it is dead or alive you cannot tell. Equally in tuberculosis you cannot by the microscope distinguish a living from a dead bacillus."

I could not induce my friend to go further as regards the possible presence of the bacillus in fish than to admit that it might be. "May it not exist, possibly, in a spore form?" I urged.

"We cannot tell. It is possible, but, as far as our present knowledge goes, the leprosy bacillus is found exclusively in human tissues. It may have other hosts; we cannot say. We must wait. I do not believe that it has ever been found in other animals. All experiments in the inoculation of animals have failed, and I do not believe they ever suffer from leprosy, for if they did it would be very common."

I pressed Dr. Hansen on the question as to whether leprosy had not begun to decline in Norway long before any laws for seclusion were enacted, and read to him the statement from Dr. Hillis that between 1856 and 1873 it had diminished 50 per cent. I suggested that the census of lepers in 1856 was probably an exaggeration.

He thought that the 1856 total was rather under than over the mark, and said that there were some reasons for supposing that the disease was rather on the increase up to that date. The present leprosy law was, he admitted, enacted only in 1885, but prior to that the Government had provided the Lundegaarde Hospital as a refuge—partly for treatment, and partly to prevent leper marriages, and thus a great many had been isolated. Dr. Danielssen, who was the first Norway physician to take the subject up, was to the day of his death a firm believer in the inheritance of the disease, and this led to efforts on the part of the Government to seclude lepers, and so prevent the breeding of children. It was under this regime that the decline began. Prior to 1885 there had been laws dealing with vagrants, and, in a certain sense, with leprosy, but they did not enforce segregation.

I expressed doubts as to whether, seeing that one-third of the lepers in Norway are still at their own homes, and are not compelled to live in separate houses or even in separate rooms, it can be claimed that anything like complete segregation is accomplished even at the present time.

Dr. Hansen admitted that compulsion was very rarely indeed resorted to. The law, he said, did not give the authorities in Bergen power to fetch lepers who did not wish to come; but the local or parish authorities could send them if they wished to, and could use force if necessary. Practically, however, they scarcely ever did so. It was usually sufficient to use persuasion or to advise care and allow the patient to remain at home.

“How do your lepers travel when they are *en route* to Bergen or Trondjem?”

“They must go in the packets.”

“Yes, but do how you protect the rest of the passengers? In Cape Colony, where the utmost fear of contagion prevails, it is a source of much expense to the authorities to provide separate conveyances for the lepers when being taken to the asylum.”

Dr. Hansen, in reply to this, appeared to think that but little fear was felt in Norway. On some of the steamers, he said, there was a special cabin for prisoners, and when this was the case he believed that lepers were put into it, otherwise they mixed with the rest of the passengers.

Dr. Hansen thought that the statement which I had read to him from Dr. Hillis as to the 50 per cent. diminution in leprosy between 1856 and 1873, when there was no efficient isolation, was probably an exaggeration; but he made no doubt that the decline had at this time begun very definitely.

"In Norway," I asked, "do you often see leprosy in children?"

"I cannot from memory give you statistics, but we see some. It is a very remarkable fact, that when the children in a family suffer there is usually, or always, more than one, and they are all of nearly the same age, that is, in close succession to each other."

To this I remarked that I had been struck with the same fact more than once in South Africa, and that I had explained it by supposing that in each instance they had all been infected by a leper who had sores on his hands and from whom they had accepted food.

"That may be, but I have explained it otherwise; I have thought that they caught it one from the other by sleeping together."

I said that I preferred my own explanation, for on his it did not seem likely that the contagion would ever cease, nor did his theory offer any explanation of the restriction to children, whereas mine suggested that when the sores on the leper's hands were healed, he ceased to be a source of infection, and it was obvious that young children would be much more likely than adults to accept food from foul hands.

In reply to my question, whether in Norway at the present time leprosy is wholly confined to the poor, Dr. Hansen said that it is not, and that sometimes quite well-to-do farmers or members of their families suffered. It was an important part of his duties to visit annually the leprosy districts to give advice and ascertain whether due precautions were being taken. On such occasions it was sometimes his lot to take meals in the same room with a leper, but the latter was sitting by himself at a separate table.

I enquired whether, seeing that none were ever dismissed

"cured," there were not some patients who had been in the Bergen Hospital for many years.

"Oh, yes; many. We have some who have been there since 1856."

"These are, I suppose—excepting for the deformations which have resulted from the disease—apparently well."

"Yes; quite so. They have mostly been for many years quite free from active symptoms."

"But you do not call them 'cured'?"

"I cannot call any patient 'cured' in whom the bacillus is still present, and Dr. Lie's recent observations have shown us that even in the very best cases of apparently complete recovery it may still be found. Therefore we have no cures of leprosy."

"You acknowledge, however, that if a leper can be kept alive, there is a tendency in the disease, so far as its active processes are concerned, to come to an end."

"Certainly. In all cases after some years all active leprotic processes come to an end. Leprosy is not in itself a fatal disease. I have scarcely ever known a patient to die of leprosy. When a leper dies, it is almost always of something else. Keep a leper alive and he will after a time seem to get well, but you cannot call him 'cured' for the bacillus is still in him."

"But perhaps it is dead?"

"We cannot tell that."

"What you say interests me very much for it corresponds with my own observations of leprosy and also with what occurs in certain tuberculous affections of the skin, more especially with what we see in lupus erythematosus. That disease is often aggressive for several years, but always comes to an end eventually. May I ask whether you ever see cases in which the disease after having appeared to have subsided has relapsed and again assumed activity?"

To this Dr. Hansen replied in the negative.

During a visit to the Polyclinic Museum, I directed Dr. Hansen's attention to a screen on which deformities of the nose resembling those of syphilis are shown in lepers, and asked whether he was of opinion that in most of them syphilis complicated the leprosy.

He replied that he had never in any single case seen disease of

the bones of the nose or of the alveolus of the upper jaw produced by leprosy. When such was present he should suspect syphilis, but on the other hand, leprosy alone might undoubtedly destroy the alæ and cartilaginous septum and cause the nose to fall down much as is seen in syphilis. He recognised many of the portraits exhibited as those of his own patients and in none of them was he inclined to believe that syphilis was present. He admitted, however, that it was difficult to be sure.

In speaking of the history of leprosy in Norway, Dr. H. told me that the St. Georg Hospital in Bergen dated from the middle ages, having been founded in 1270. Until the time of Dr. Danielssen, nothing in the way of scientific observation had been done and there was no literature of an earlier date. At Dr. Danielssen's instigation, the present Lundegaarde's Hospital was built at the Government expense in 1845. The chief object then in view was treatment and cure, but it was also hoped to prevent hereditary transmission by discouraging marriage. Although there was no compulsion and although segregation was not the main object, yet the hospital, so far as its accommodation went, had of course, some influence in that direction. The name Lundegaarde is simply that of the former owner of the ground. The Old St. Georg Hospital, perhaps the last mediæval one remaining in Europe, is likely to be soon pulled down. Against this vandalism I protested, but the reply was that the land was valuable and was wanted for other purposes.

Dr. Hansen expressed himself very strongly indeed to the effect that no one had as yet made any approach to the cultivation of the *lepra bacillus*. Everything that had been announced in that direction had been, he said, a mistake. He also said that attempts to diagnose leprosy by examination of the blood were illusory. The bacillus is not present in the blood excepting in small numbers and is very difficult of detection.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

THE INTRACRANIAL COMPLICATIONS OF SUPPURATIVE MASTOIDITIS.

BY FREDERIC S. EVE, F.R.C.S.

[*Abstract.*]

THE lecture included a discussion of the several intracranial complications which may attend suppurative or septic inflammations of the tympanum, the internal ear, and the mastoid antrum, the various features of clinical interest being illustrated by the relation of actual case-records. The conditions described were:—

(1) *Pachymeningitis Externa*.—This is the least important of the intracranial complications of suppurative ear-disease. The external surface of the dura is thickened and presents villous granulations. When existing alone it may be regarded as a danger signal. It may, however, be associated with the presence of pus between the bone and the dura mater. A similar condition may be present on the deep surface of the dura.

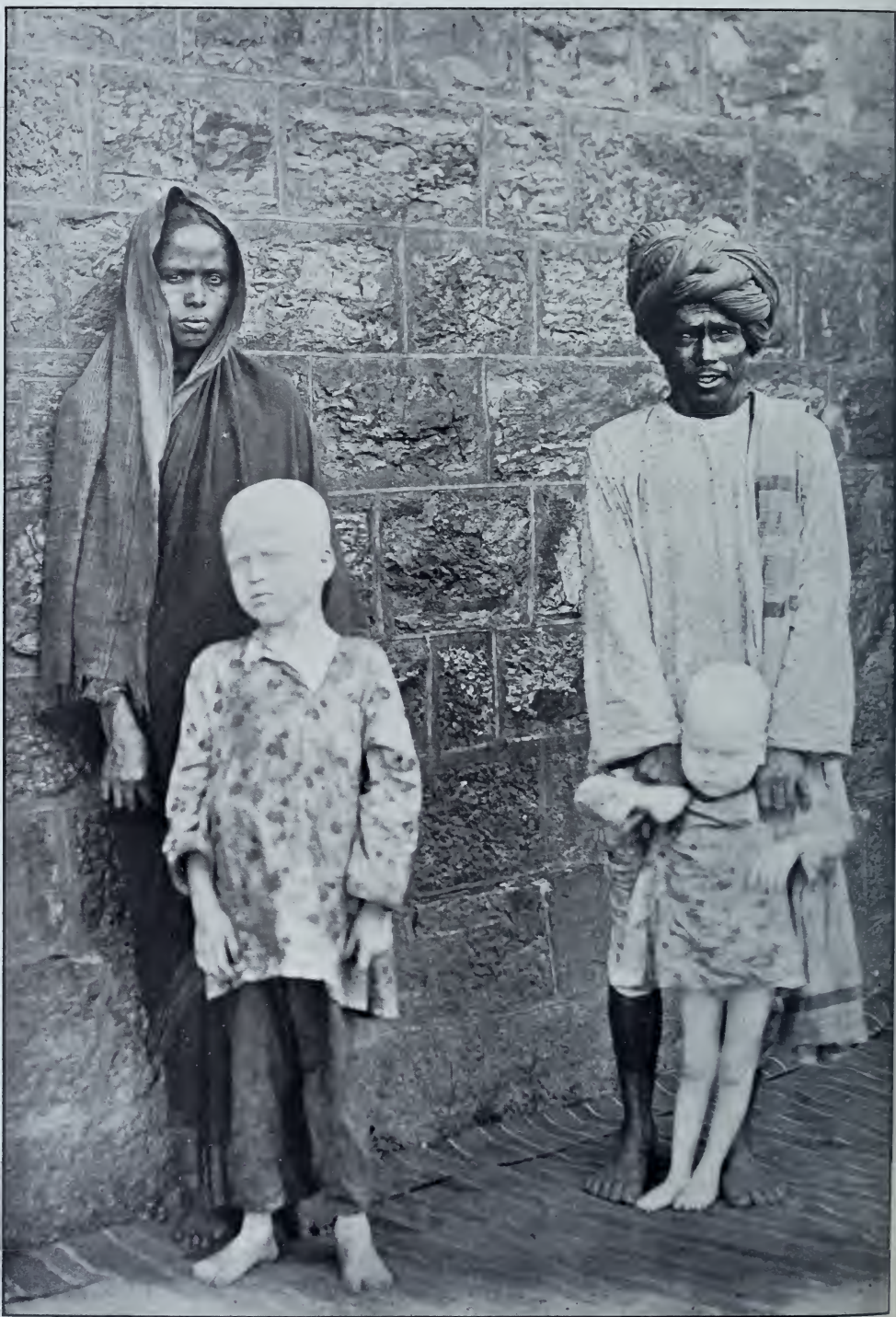
(2) *Extradural Abscess*.—This may occur in various situations, but is most common over the sigmoid sinus. When it follows a suppurative mastoiditis the sinus—as a result of absorption of the bony plate which separates it from the antrum—may be actually bathed in pus. Yet the symptoms of this serious condition may be comparatively slight—perhaps nothing more than pain over the side of the head, with moderate pyrexia and more or less otorrhœa. Even when the bony walls are intact, and the pus is therefore confined under pressure, the symptoms may be hardly more marked, and in particular, rigors may be entirely absent, and the temperature

equilibrium may be but slightly disturbed. Fortunately, when the antrum is opened, the presence of pus around the sigmoid sinus is often indicated by the oozing of pus through a small channel opening on the posterior wall of the antrum. The condition is met by enlarging, in the appropriate direction, the opening made in the operation of mastoidectomy.

(3) *Thrombosis of the Lateral Sinus*.—This may arise in various ways as the result of septic processes in the tympanum and mastoid antrum. The general symptoms are those of pyæmia—due to the occurrence of septic embolism and septic intoxication—added to those of acute mastoiditis. The only distinctive local signs are those due to extension of the clot into veins communicating with the lateral sinus. Thus there may be a “cord-like” induration along the course of the internal jugular vein, and tenderness at the apex of the posterior triangle due to thrombosis or phlebitis of the posterior cervical veins. Thrombosis is apt to be accompanied by cessation of the otorrhœa; unless this is remembered it may cause a doubt as to the true nature of the case. The aim in diagnosis is to recognise the existence of thrombosis before the clot has commenced to disintegrate—otherwise, when general pyæmia has set in, the patient's chance of recovery can only be slight. It should be the rule in cases of otorrhœa that when pyrexia, vomiting, drowsiness, or incontinence of urine is present, the lateral sinus should be exposed, and if doubt still exists as to the presence of clot, the sinus should be opened.

(4) *Meningitis*.—This may be of several varieties. Septic leptomeningitis, serous meningitis and posterior basal meningitis were instanced, and their diagnosis was discussed and illustrated by clinical examples.

(5) *Cerebral Abscess*.—This may be situated either in the temporo-sphenoidal lobe or in the cerebellum. Symptoms common to the two are vomiting not related to food, intense pain sometimes paroxysmal in character, foul breath, rigors ranging from slight chill to severe shivering, giddiness, and lethargy. The last-mentioned is most significant. The patient may appear comatose, but is capable of being roused, or there may be merely a sluggish and clouded state of the mental functions. The temperature shows a sudden fall from the septic type, which accompanies mastoid in-



ALBINISM IN A FAMILY.

From photograph by Major GRAYFOOT.

flammation, to normal, and during the night or in the early morning may be sub-normal. Pulse and respirations may be slow, particularly in large abscesses. In many cases, however, the pulse rate runs up to 120 or so. Optic neuritis is usually present. There may also be paralysis, usually affecting the lower muscles of the face and the upper limb in the case of temporo-sphenoidal abscess. Cases were related to illustrate the clinical features of the two varieties of brain abscess, and the manner in which each may cause paralysis was discussed. The pathology of the conditions was also referred to, and the methods of operating were described. The lecture was illustrated by numerous diagrams and charts.

ON FAMILY DISEASES AS ILLUSTRATED BY ALBINISM.

BY JONATHAN HUTCHINSON, F.R.S., L.L.D.

GENTLEMEN,—A very interesting photograph from India has been given us by Major Grayfoot. It shows two albino children of dark skinned parentage together with their father and mother. The two children are quite white, while their parents are both black. There is nothing novel in the fact illustrated, but the demonstration of it is more graphic than you can often see it. In this respect it is very useful, for it serves to impress a very important law. It has been long well known that negroes and other dark-skinned races are liable to albinism. It has even been suggested that they are more prone to it than are the white races. I do not think that there is any satisfactory proof of this, and we may be content to think that the suspicion is due to the circumstance that the condition, from being so very conspicuous, attracts more attention in them. As a matter of fact, albinism occurs throughout almost the whole animal kingdom. It is not, however, equally common in all species, and in all in the perfectly wild state it is very rare. We must not allow ourselves to infer anything from what occurs in domesticated or semi-domesticated animals, for here transmission under conditions of protection may come into play. As everyone knows, albino ferrets,

rabbits, mice and rats are very common, whilst the like are almost unknown amongst sheep, cattle, goats, horses, asses, and many others. One is sometimes tempted to suspect that a liability to become piebald—in other words, to assume local albinism—saves the species in which it occurs from the risk of the complete condition. We have plenty of piebalds amongst our domestic animals, and also of those which are wholly white excepting as to the eye, but by the very rarest chance do we see a complete albino. It is in the eye that the pigment fails last, and the animals referred to always keep it there. The rabbit and the rat are, however, exceptions to this, for they may be either piebald or albinos. Albinism once developed, is easily inherited. We see this in rabbits, mice and ferrets. I do not know any instance of an albino human being having become a parent, and probably the condition is generally considered a bar to marriage. It is one of the conditions which have been claimed by the opponents of the marriages of near relations as likely to result from them. Darwin, quoting from a Dr. Devay who wrote a book on the danger of consanguineous marriages, relates a story of two brothers who married two sisters who were their first cousins, the result being that the seven children born from the two marriages were all albinos. It is added that there was no history of albinism in the families previously. The story is so complete that it is difficult not to suspect some exaggeration, at any rate we may feel sure that if true, it illustrates what is exceedingly rare. Not only do the marriages of first cousins hardly ever produce albinos, but the fact of a whole family being in that condition is quite unprecedented. In the case before us there were nearly as many black brothers and sisters in the family as there were albinos, and this is the rule. It is the same with retinitis pigmentosa, ichthyosis, lentigo, maligna juvenilis (Kaposi's disease), and some others. They are what are called "family diseases," but they never affect all the members of any given family. We should have liked to know from Dr. Devay not only whether there was no history of albinism in the family, but whether any of the predecessors had been of remarkably fair complexion. In the human race we certainly have, what I do not think are ever observed in the lower animals, incomplete albinos in the sense that the pigment failure is universal, including the eye, but nowhere quite complete.

The occurrence of the "family diseases" which have just been named makes it seem certain that it is possible for the union of two individuals to involve the risk of failure in the development of some one of the tissues, which failure shall show itself in several of the family if there be many in it. But perhaps after all it is no more than this, that one of the parents has in his or her organisation this risk, and that the children who suffer are those who take after that parent. There is, you will see, a shade of difference, possibly a very important shade, between this hypothesis and that of the result being due to the combination. It would, for instance, much better explain what is asserted in Devay's case, for we should have but to suppose that there existed this tendency in both sisters or in both brothers, and that it was not strongly counteracted by the consort, owing to relationship. In this way the case comes into the category of hereditary transmission only and proves nothing against consanguinity in marriage *per se*. It becomes charged against the latter only that it fails to counteract hereditary proclivity.

Dr. Grayfoot's photograph has led me much further into disquisition than I had intended to go when I first produced it before you; but there is yet one other question which must be entertained respecting albinism. Is it a form of reversion? On the theory that primeval man—or more correctly some non-human predecessor far more remote—was destitute of pigment, it might be so ranked. We may note that converse conditions are not known, we do not encounter negro-skins amongst white races. On the contrary, in the ovine species there is a constant tendency to revert to a dark ancestor, and black sheep born of white parents are not uncommon; whilst all young lambs are speckled black and only become white as they advance in months. The reverse is the case with the negro baby. It may, therefore, be the fact that—as the negro himself believes,—the blackness is an acquisition and an adaptation, and the failure of it a reversion towards a less well-endowed ancestry. As a matter of physiology, we may conjecture that there is in the organism a pigment-forming function somewhere and that albinism results from its suppression.

Dr. Joseph Adams, who wrote in 1814, thought himself justified in asserting that "family diseases" were never hereditary. By this he meant that the peculiar diseases such as albinism,

ichthyosis, &c., which occur in several members of one family, are never to be traced to any ancestor. In this creed he was for the most part in accord with facts, but not, I think, wholly so. Unquestionably these affections are often produced *de novo*, that is, without any recognised inheritance. It is another thing, however, to assert that they are not transmissible, and in this we may easily be deceived owing to the fact that their subjects rarely marry. Certainly albinism can be transmitted and so also may ichthyosis (witness the case of "the porcupine man.") I have also recently seen an instance of the peculiar and rare condition known as epidermatolysis occurring in several children, the offspring of a mother who had suffered from it. We may, then, safely believe that the statement that all acquired peculiarities, excepting those due to mechanical violence, may be inherited, finds no real exception in the case of "family diseases."

ON A NEW TYPE FORM OF ANGEIOMATOUS LUPUS.

GENTLEMEN,—I feel sure that most present will remember a very interesting and important case which was brought under our observation two weeks ago by Dr. Day. Its subject was a young woman, nearly 20 years of age, of rather delicate aspect, and with a history of tuberculosis in some relatives. She was not herself, however, out of health. The skin disease for which Dr. Day brought us his patient consisted of large patches of angiomaticous congestion of a very peculiar kind. These patches were arranged with fair bilateral symmetry, but were not always of equal size on the two sides. They occurred chiefly on the limbs. One, as large as an outspread hand, was on the inner side of the right thigh, others were on the knees, and a very conspicuous one was on the front of the left shoulder. There were none on the face, and I think none on the trunk. The term angioma is more applicable than that of erythema to the condition of dilated capillaries which characterised the patches, for it was persistent, and had been so for some years. The blood vessels could be emptied by pressure, leaving the skin

pale, but they filled again instantly when the pressure was removed. There was not the slightest thickening or induration of the affected parts, nor any desquamation. The patches were mottled with very superficial and ill-characterised cicatrices. The margins of the large areas were indefinite, and their surfaces consisted of tufts of dilated capillaries. They differed from *nævus* in that the angeiomatic condition was mottled and not continuous, besides they had not been present at birth, and further, who ever heard of *nævi* arranged with bilateral symmetry.

I will read to you the notes of a somewhat similar case. It differed, however, in the important feature that the condition was not bilateral.

"A remarkable case, which might possibly be in some sense a connecting link between these rare forms of infective angeioma and tuberculosis, came under my observation in the person of Miss H., of Liverpool. Miss H. was nearly twelve years old when I first saw her, a blue-eyed, fair, and healthy-looking girl, of a clear and delicate complexion.

I was in the first instance shown a large patch of erythematous discoloration on the back of the right hand and wrist. It looked like a "port wine stain" *nævus*, but I was assured that it had not been present at birth, and had not indeed been noticed till she was five years old. Both the child and her mother were certain that it had increased of late, and that fresh spots had formed near its borders. Higher up on the arm, a little above the elbow, there had recently appeared another similar patch. This was a long, broad streak of congestion, by no means very conspicuous. The blood was discharged by the slightest pressure from the affected parts, but returned instantly. The colour was a dusky red, in parts slightly purple. There was not the slightest thickening, nor any tendency to form vesicles, or tufts, or rings. The patch was very irregular in shape, and had many smaller detached ones near its margin. Although it caused not the slightest inconvenience, it was conspicuous and disfiguring, and the child's mother was very unhappy about it. It covered the greater part of the radial half of the back of the hand and wrist.

The following facts are of interest as regards family history:—The child herself had suffered much from chilblains, but otherwise had enjoyed good health and a remarkably clear skin. Her father had been always a little delicate, and one of his brothers had died after abscesses (? spinal). Her maternal grandmother, still living, had suffered severely for many years from rheumatic gout and "gouty eczema" of a severe type. She had two brothers and a sister all in good health.

There seemed to be proof in this case that an angeioma which had begun in early life was persistently infective. In this feature the case ranges itself with the erythematous or *nævoid* forms of *lupus lymphaticus*."

In Dr. Day's case there were some features which led me to consider it as a lupoid form of *lichen scrofulosorum*. There was nothing of a definitely lichenoid character in the case of which I have just read to you the notes.

ON A CASE OF ARSENIC-CANCER.

(Concluded from page 340.)

AMONGST the drawings in the arsenic series in our Museum is one which shows what at first sight would be taken for a perforating ulcer of the sole. It represents the condition of things in an elderly gentleman who was sent to me in 1887 by Professor Chiene of Edinburgh. The ulcer was superficial; it had begun as a sort of corn and it did not perforate. There were corn-like indurations, and in the soles at other parts, and also in the palms of the hands. The general condition of the skin led me to diagnose arsenic cancer, and this suspicion was confirmed by the fact that our patient had been the subject of psoriasis since the age of ten and had taken arsenic for its cure. I cannot give further details than that he began in early life and had "taken it at times for many years." The ulcer was subsequently excised, scraped, and burned by Mr. Chiene, and it healed, leaving only a thickened horny cicatrix. Some of the portions excised were very carefully examined by the microscope (by Dr. Mackay) and conditions suspicious as to epithelial cancer, but not conclusive, were found. Subsequently a malignant ulceration occurred on the skin of the leg, and a few years later the patient died of cancer of the stomach. I am indebted to Professor Chiene for these facts as to the final result, for I saw the patient myself only once. A narrative which was supplied to me by Mr. Chiene from the pen, I believe, of his assistant, gives some important details and mentions the fact that there had been some neuritic paralysis. I may add that the patient also wrote me his own account, and stated that he had suffered from neuralgia and from what he called "chordee without pain," and that he had once nearly died from "a kidney and bladder attack." I will read to you the more important parts of the narrative supplied to me:—

Mr. C.'s Case.

History.—Bunion of great toe, which through time had opening into the metatarsophalangeal joint, and this joint was eventually excised by Professor Spence. The wound healed. Has for many years been troubled with the tendency to formation of corns on hands and feet and general hypertrophy of the cuticle. The skin is dry and harsh, and on both legs and arms there is well-marked psoriasis on the extensor aspect of the limbs. Has lost to a great extent the power of feeling in right hand, so that he does not know when he is grasping a pen and has now to write with his left hand.

Present condition of foot. December 6, 1886.—The skin on sole of foot is dry and rough, and over ball of great toe there are two ulcers, one the size of three-

penny piece, the other about half that size. The skin around these is much thickened. The great toe is lying under the other toes at right angle to long axis of the foot.

Patient states that these ulcers are in the place where for several months he had two hard corns which he was in the habit of having pared by a Chiropodist.

After much detail as to the treatment which had been pursued with no good result the narrative proceeds:—These means having failed, the patient went to Harrogate and stayed there for three weeks with marked benefit to his general health, but although the skin of foot was softer the ulcers had not improved.

In June, he went to London, and on the advice of Mr. Jonathan Hutchinson returned to Edinburgh to get the tissue around and forming floor of ulcers cut or burnt out.

On June 24.—This was done. The edges of ulcers and bridge of tissue between them was cut away while the floor was burnt with chloride of zinc (solid), and afterwards treated with boracic powder. The slough came away in a week and then the edges and floor of wound were seen to be healthy and healing in appearance. In three weeks there was a marked diminution in the size of the ulcer and on August 25 it was quite healed by strong tissue, while the skin around was softer than before. Since then he has had no trouble, and the foot is quite strong and well.—Edinburgh, *December 5, 1887.*

Dr. Gilletti of Turin was good enough to send me a copy of a well illustrated paper on a case of “Symmetrical Kerato dermatitis.” The palms and soles were affected. The illustrations have been copied for the new Sydenham Society’s “Atlas.” A man, aged 25, had taken arsenic for “urticaria” from 1889 to 1893. At the latter date he came under Dr. Gilletti’s observation. The condition had continued to increase for two or three months after the disuse of arsenic, and was in *statu quo* ten months later still.

Hans Hebra published under the title of “Keratosi Verrucosa, Palmæ, &c.” in the *Arch f. D.N.S.*, 1890, the case of a young woman, models of whose feet were exhibited in the Vienna Museum. It was afterwards proved that she had been secretly taking arsenic as a cosmetic.

I now have to ask your attention to another division of our subject, that, namely, which concerns the direct application of arsenic to the skin and mucous membranes. There can, I think, no longer be any doubt that it is the arsenic which is present in city-made soot which causes chimney-sweep’s cancer.

It gives me extreme pleasure to be able to add another leaf to the laurel-chaplet which encircles the brows of my distinguished teacher and friend, the late Sir James Paget. He had observed with the utmost accuracy and described in vivid language, without a redundant word, all the features of the arsenical skin. The only point which he missed, and it was one which until the last few

weeks we had all contrived to miss, was the fact that it was due to arsenic. I will read to you from his Lectures on Pathology what he there says as to the state of the skin met with in chimney-sweeps, and ask you to compare with it what we have just had under observation in our patient with arsenic-cancer.

“A similar drily scaled or incrustated warty change of the cutis often, I believe, precedes the chimney-sweep's cancer; and I suspect that the true influence of the soot in this disease is not that its continued contact determines the growth of cancers, but (at least in part) that it produces a state of skin which provides an apt locality for epithelial cancer in persons of cancerous diathesis. How it does this I cannot imagine, but this is only one of many things unexplained in this strange disease, for the whole of the peculiarities of the chimney-sweep's cancer—its dependence on soot, while coal-dust is wholly inoperative (for the disease is unknown among colliers); its comparative frequency in England, especially in the large towns, while in other countries where soot is abundant it is hardly seen; its selection of the scrotum for its most frequent seat—all these, and many like facts in its history, appear completely inexplicable. Still, it is certain that scaly or incrustated small warts, such as I have been describing, are very common in chimney-sweeps. In many of them, even when they are thoroughly cleaned, the whole skin is dry, harsh, and dusky, and, before operation for the removal of scrotal cancers in them, it is a common question whether one or more warts or scaly patches near the chief disease should be removed with it. Nor are such warts confined to the scrotum, they may exist on every part of the trunk and limbs; and I have seen sweeps so thick-set with them, that a hundred or more might have been counted.”—*From Lectures on Surgical Pathology by Sir James Paget, page 718.*

From evidence procured by the Royal Commission on Arsenical Poisoning we learn the following facts as to the presence of arsenic in soot:

Soot deposited in the flue of a chimney after burning good house coal for one week contained per pound of soot 5·6 grains of arsenic. Soot deposited in the flue of a closed stove after burning Corporation Gas Works Coke for 15 days—per pound of soot, 28 grains of arsenic.

No appreciable amount of arsenic has been obtained from the soot produced by burning purified gas (as supplied to the consumer).

There are yet two or three matters to which I wish to advert.

We may speak of “sugar-arsenic and malt-arsenic,” the former being the kind recognised in the epidemic at Manchester and other places, and to be regarded as due to almost culpable carelessness, the latter connected essentially with the making of beer from kiln-dried malt, and preventible only by special precautions.

The worst specimen of sugar-arsenic beer analysed by Professor Delépine contained no less a quantity than a grain and a half of

arsenic to the gallon, and another showed nearly a grain. The others ranged from a quarter of a grain to a twenty-eighth. One of the worst specimens of Bostock's sugar (glucose) might have supplied not less than three grains and an eighth of arsenic to the gallon of beer.

Of the "malt-arsenic" beers, none have been found to in the least approach the quantities in the sugar-arsenic ones, one twenty-eighth of a grain to the gallon being a high ratio. Most of the specimens of malt examined could not have yielded more than a hundredth of a grain to the gallon. In the lager beers of Munich and Vienna no arsenic has been found.

You will see that my suspicion as regards the influence of arsenic in causing cancer is that it is exerted upon all the tissues of the body, and that it enters into partnership with others such as inheritance and senility.

To Dr. Sims Woodhead we are, I believe, indebted for the demonstration that the papillæ of the skin in their relation to the cutis and epidermis become more and more complicated as age advances, and for the suggestion that this may explain the proneness of the senile skin to develop epithelioma.

A very important point to be established is that the form of cancer produced is not invariably epithelial, and that it is by no means restricted to the skin. I have repeatedly known cancer of the stomach to occur in those who had taken much arsenic and in some instances visceral growths. In some of my most definite examples of arsenic-cancer, more than one form of malignant disease was present at the same time in the same patient. The case which has been before us offers a good example of this. Epithelioma of the skin occurred in two distant parts, and near to one of them a subcutaneous growth was produced, respecting which the Clinical Research Association reported: "This portion is very extensively invaded by soft carcinoma of the acinous type. The stroma in many places is scanty."

It seems not improbable that the inhalation of the vapour of arsenic is far less hurtful than the swallowing it in solution, or even in inhaling it as dust. The evidence as to the diseases induced in those who work under conditions exposing them to the vapour, although not unanimous, does not support the belief that they suffer in any special degree from cancer or keratosis, or peripheral neuritis.

I have lastly to ask your attention to an exceedingly important topic, but one upon which as yet nothing is conclusively established. The increase of cancer, which has attracted so much attention of late, has been shewn to have occurred chiefly in men. Now what is the kind of cancer to which men are chiefly liable? It is epithelial cancer of the mouth and associated parts. If we may for our present purpose include under the term "mouth" the lips, tongue, throat, gullet, and stomach, we shall find that men suffer from cancer of the "mouth" in far greater proportion than do women—perhaps I might say six men for one woman. Why should this be? Can anyone suggest any other reasonable explanation than that the cause is smoking? If, then, we may believe that four-fifths of the cases of mouth cancer are really due to smoking, the next question is, what is the nature of the influence which tobacco-smoke exerts? Is it merely heat, is it the irritation of nicotine, or the drying of the mouth by the partial arrest of salivary secretion, or lastly, is there arsenic in the tobacco¹? Not much has as yet been done in the analysis of tobacco in search for arsenic, and the results as yet obtained do not entitle me to say more than that the search must be continued, and on an extensive scale. It may easily be the fact that whilst some tobaccos contain it the majority do not. The tobacco in use in some countries—for instance, that smoked in New Zealand—lies for the present under much greater suspicion than that of most other places.² Let me repeat, it is for the present a plausible suspicion only, and if in the end it should be proved to be a fact there will still be no ground for great alarm. The danger once known will be easily avoided, and after all in the long run a little arsenic probably does more good than harm.

¹ Dr. William Murrell in 1896 drew attention to arsenical risks of smokers. He however, only, proved the presence of arsenic in the coloured paper in which tobacco and cigars are often sold.

² The following statement as to the drying of tobacco leaves may be of importance:—"In the United States the quick drying process by artificial heat is employed principally for export tobacco. Formerly the heat was obtained by means of an open charcoal fire within the curing barn, but now the structure is heated by a system of flues which permits the burning of any kind of fuel." (*Encyclopædia Britannica*, vol. xxiii.) It does not follow from this that the leaf is actually exposed to the fumes from the coke which is probably the fuel often used, but a dangerous possibility is suggested. The fumes of coke contain arsenic, and just as the malt dried by coke becomes almost inevitably contaminated, so may the leaves of tobacco.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY C. O. HAWTHORNE, M.D., M.R.C.P.

Tuesday, June 17, 1902.

A Case of Congenital Spastic Paraplegia.

THIS boy is three years old.¹ He has never walked, and it is this defect which has led his mother to seek medical advice. Not very infrequently we all see cases in which the acquisition of the art of walking is postponed to a relatively late age without any very obvious cause, but in the present instance there is evidence only too abundant and distinct that the lad's disability depends on organic disease in his central nervous system. As he stands supporting himself by a chair you observe that he rests on the fore-part of his feet and does not put his heels to the ground. Again, when he attempts to walk, his mother holding him by his armpits, he crosses his thighs alternately one in front of the other as he moves forward. His gait, in other words, is a quite characteristic example of what is called "cross-legged progression." The immediate cause of this is easily determined. When I try to abduct the thighs you notice I am only able to do so to a very slight extent, and this because of the resistance of the adductor muscles. These muscles are rigid. They are in a state of tonic spasm and so keep the thighs drawn towards the middle line. A similar state of matters is found in other muscles of the lower limbs. The rigidity of the quadriceps extensor

¹ This patient was shown to the Society for the Study of Diseases of Children on February 21, 1902.

femoris prevents flexion of the knee, and a similar condition of the calf muscles draws up the heel and prevents the foot being placed flat upon the ground. There is no doubt that the rigidity is due to muscular spasm, for it varies in degree at different dates. It never, however, wholly disappears, and, indeed, is always present to an extent sufficient to cause the peculiar gait you see to-day. These facts in themselves are sufficient to enable us to place a descriptive name on the boy's condition. As he has defective voluntary power over the movements of his lower limbs, we may certainly speak of the case as one of paraplegia. Further, as the paralysis is accompanied by tonic spasm or rigidity, we may speak of it as an example of spastic paraplegia. And as it has certainly been present from a very early age, we may select as the fully descriptive name the term congenital spastic paraplegia. But it is possible to go somewhat further. We have the facts of paresis and of tonic spasm. To these, as you see, we have to add marked exaggeration of the knee-jerks and very decided ankle clonus. Now tonic spasm and exaggerated tendon phenomena can only mean excessive activity and excitability of the motor cells in the anterior cornua of the spinal cord; and such excessive activity and excitability result from degeneration of the lateral columns of the cord, that is, of the fibres of the pyramidal tracts, which, taking origin in the motor areas of the cerebral cortex, descend to convey the motor impulses to the cells of the anterior cornua. These cells, as a consequence of such degeneration in the lateral columns, are no longer under the control of the cerebral centres. Hence they discharge more energetic nervous impressions and so keep the muscles in a state of tonic spasm; and their increased excitability accounts also for the exaggeration of the tendon phenomena. We are therefore in a position to advance the diagnosis a stage. Clinically the case is one of congenital spastic paraplegia; pathologically it is an example of degeneration or sclerosis of the motor nerve fibres in the lateral columns of the cord, and thus might be spoken of as a case of lateral sclerosis. The clinical facts, in other words, enable us to make an exact anatomical diagnosis and to conclude that there is degeneration in the lateral columns of the spinal cord. But we are still without any suggestion as to the cause of this degeneration. Is it a primary change, a gradual decay, as one may say, of the nerve fibres in the lateral columns? Or is it

the result of changes situated at a higher level, perhaps in some part of the brain? We know that when the pyramidal tract is interrupted, the lower part, separated by the lesion from its organic connection with the cerebral cortex, undergoes degenerative changes. There is in these circumstances a descending degeneration which passes down the tract in the lateral column, and among the clinical evidences of this are muscular rigidity and increased tendon jerks. The question in the present case is whether the lateral sclerosis, which undoubtedly exists, is or is not of this secondary order? or, to put the question in another form, Is there, or is there not, reason for believing that the primary event in our patient was a cerebral lesion and that the degeneration in the lateral columns is a consequence of such lesion? Now we have little or no evidence of any affection of the brain. The boy's head is quite well formed. He has never had convulsions, each fundus oculi is normal, and for his age he is a sharp, observant, and intelligent child. It is true he has a slight degree of convergent strabismus, but this is so frequent an event in children, as a consequence of more or less hypermetropia, that it would be a very narrow and insecure basis on which to rest a theory that the lad is the subject of organic change in his cerebral centres. But when the present case is considered together with others more or less obviously allied to it, a good deal may be said in favour of the view that its ultimate interpretation is to be found in the shape of a cerebral lesion. Thus there exist cases in which a condition of the lower limbs similar to what we have here is associated with more or less paralysis and spasm of the arms; in others, again, the muscles in the lower part of the face may also be paralysed. And with any one of these conditions there may be evidences of mental impairment—this ranging from a slight degree of mental dulness at the one extreme, to complete idiocy at the other. It is to be noted also, that a patient who in his early years is the subject of spastic paralysis, and who appears mentally acute, may later develop progressive mental deterioration. There thus appears to be a graduated series of cases commencing with simple spastic paraplegia and passing through growing extensions of the paralysis up to paralysis associated with mental impairment undoubtedly due to changes in the cerebral cortex. Supposing, at least for the moment, that our present case is of this order—that is, that it depends on a cerebral lesion—let us consider where the lesion must be situated.

As both lower limbs are paralysed and spastic, both lateral columns must be the site of sclerosis. Assuming that the sclerosis is the result of a cerebral lesion, this must, therefore, be so placed as to command both motor tracts, or rather those portions of the two tracts which are related to the movements of the lower limbs.

But there is only one situation in which any single lesion can possibly command both tracts, omitting the crossing of the tracts in the medulla, where a lesion would produce a very different picture from that of uncomplicated spastic paraplegia. That one situation is at the vertex of the hemispheres, immediately over the upper extremity of the fissure of Rolando. Here it is easily conceivable that a single lesion—for example, a hæmorrhage—by extending a short distance on each side of the middle line, might readily destroy the nerve centres in that neighbourhood, and it is these nerve centres which control and determine the voluntary movements of the lower limbs. There can also be no difficulty in understanding how, by an extension of the lesion outwards from the vertex on one or both sides, one or both upper limbs may be involved in the paralysis. Similarly, a lesion passing forwards may affect the centres which govern the movements of the eyeballs, or by extending into the pre-frontal region, may damage the mental functions. In this way may be explained the different distribution of the paralysis in the cases above alluded to, and also the various degrees of mental defect which occur in these cases.

Thus it is a conceivable view of our case that the first event was damage to the leg centres situated at the vertex of each hemisphere; that as a consequence of this a descending degeneration has occurred in each pyramidal tract; and that the spastic paraplegia, equally with the sclerosis in the lateral columns, is, when the analysis is carried sufficiently far back, a result of the brain lesion. If this view is to be accepted the case must be placed among the palsies of children having a cerebral origin, and may be named cerebral paraplegia.

For my own part, however, I prefer to limit myself to the diagnosis of congenital spastic paraplegia. That, at all events, does not go beyond the facts. Nor does its pathological correlative sclerosis of the lateral columns. At least it does not do so if by "sclerosis" we simply understand a condition of the lateral columns

which renders them unable to convey impressions from the motor centres of the cortex to the cells in the anterior cornua of the spinal cord. But the term cerebral paraplegia does go beyond the facts, at least in this individual case. It is, no doubt, quite true that various paralyses in children, attended or not with mental defect, have been proved to be due to lesions in the cerebral cortex. It may also be allowed that a condition of *primary* lateral sclerosis has hardly been satisfactorily demonstrated. Still the fact remains that here is a boy with spastic paraplegia (which undoubtedly means sclerosis of the lateral columns) without any proof whatever of the existence of a cerebral lesion. We cannot say positively that there is no cerebral lesion; but there is certainly no clinical evidence of it. There is still something more to be said on this point. Many of the early cerebral palsies of infancy are usually associated with a history of prolonged or difficult labour, and it is presumed that the circumstances which attend such labours cause meningeal hæmorrhage, with resulting damage of the cerebral cortex. Another association which has been noted is that of birth of the child in a state of asphyxia, necessitating artificial respiration. Now the history of our present patient is entirely free from either of these incidents. It appears that in consequence of great difficulty in the delivery of a previous child, the pregnancy of which our patient is the issue was artificially terminated at the seventh month. The labour was neither prolonged nor difficult, and the child breathed naturally from the outset. Hence, so far from the existence of conditions which are believed to produce such damage of the cerebral cortex as is likely to cause paralysis of the limbs, the circumstances attending the birth of our patient were quite of the opposite nature. To meet instances of this character, it has been suggested that in these patients there is imperfect development of the pyramidal tracts, and therefore imperfect conduction along the spinal cord of the motor impulses originating in the cerebral cortex. There is, of course, no doubt that the motor tracts are relatively late in their appearance as compared with other groups of nerve fibres in the spinal cord, and it may perhaps be possible that premature birth may find them but poorly developed, and subsequent circumstances, of which we know little, may prevent their normal expansion. All this seems, however, to emphasise the necessity for hesitation in

concluding that because many of the cerebral palsies of children undoubtedly depend on changes in the cerebral cortex, the present case, though void of any evidence of such a lesion, has the same interpretation. It may be so, but beyond admitting the possibility it would be unsafe to advance. What we are sure of is that the case is one of congenital spastic paraplegia, and that the facts which that name denotes imply imperfect function—and doubtless structural change—in the motor tracts in the lateral columns of the cord. Whether such change is a primary one, or is a secondary result of a lesion in the cerebral cortex, we cannot say. But for the cerebral theory there is, so long as we keep within the four corners of the case itself, practically nothing to be said.

One other possibility, hardly arising in the present case, yet always to be considered in examples of paraplegia in children, may be mentioned. It is the question of disease of the vertebral column. Pott's disease of the spine, we know, may cause pressure effects on the spinal cord, and among these effects may be paralysis of the lower limbs. Interruption of the motor tracts at any level of the cord will be followed by secondary degeneration in the lateral columns below the level of the lesion, just as such degeneration follows a lesion of the motor tracts in the brain. Hence the paraplegia due to caries of the spine may have a spastic character. In the present case there is not the slightest evidence of caries of the spine, and the age of the child renders it extremely improbable. Pott's disease usually occurs in later childhood, and hence, even though it leads to paralysis, there is a history of a preceding period of normal gait; whereas in the present instance the child has never walked naturally, and there has been stiffness of the legs from earliest infancy. Disease of the spine, however, should always be considered as a possible interpretation of a case of paraplegia.

From what has already been said, it is obvious that the outlook for our patient is somewhat uncertain. On any view of the pathology it is very unlikely the child will ever have complete use of his lower limbs, and if the condition depends on a cerebral lesion, we must recognise the possibility of the development of more or less mental impairment. But whilst we admit this possibility, we need hardly entertain it as a probable event in face of the reasons we have for doubting the existence of a destructive lesion

of the cerebral cortex; and even if such a lesion exists, it by no means follows that it must necessarily extend so as to produce mental deterioration. Again, there is no doubt that the paretic condition in these children often becomes sensibly improved. Therefore, while we must not offer the prospect of complete recovery, we may give the parents some encouragement to expect better things. It is not possible to pursue any particularly heroic treatment. The child must be thoroughly well cared for in every respect, and must be encouraged to use its limbs in the hope that use may improve the conduction of motor impulses through the cord. Passive movements and massage may possibly do something to prevent permanent shortening of the muscles and to avoid the deformities which result therefrom. If these measures fail, we may be compelled to endeavour to get some assistance from the resources of orthopædic surgery.

SURGICAL CASES.

BY J. JACKSON CLARKE, F.R.C.S.

Wednesday, April 23, 1902.

A Case of Congenital Dislocation at the Hip-Joints.

THE patient, a girl aged 8 years, presented considerable prominence of the buttocks and marked lordosis, with a peculiar rolling gait. The question raised was whether the diagnosis was one of congenital dislocation at the hip-joints or an extreme degree of coxa vara. It was pointed out that these two conditions have certain features in common. Thus, in congenital dislocation, the head of the femur having passed on to the dorsum ilii, the prominence of the trochanter major is found above the line drawn from the anterior superior iliac spine to the tuberosity of the ischium (Nélaton's line). But in an extreme case of coxa vara, the aggravated depression of the neck of the femur, though the head of the bone remains in the acetabulum, will also cause the trochanter to rise above the level of Nélaton's line. Again, both congenital dislocation and coxa vara limit the range of abduction of the thigh, so that here

also no confident distinction can be established. The patient when examined showed both these features, namely, an unduly high position of the trochanter major, and a very limited possibility of abduction of the thighs on passive movement. But it was demonstrated that traction on the foot readily lowered the level of the great trochanter to the extent of more than an inch, showing conclusively that the condition was one of dislocation. This diagnosis was also in harmony with the statement that the peculiarity of the gait had been observed ever since the child began to walk, whereas coxa vara usually developes after walking has begun.

Another question to be determined was whether the head of the bone was dislocated forwards or backwards. In a traumatic dislocation the direction of the foot at once provides a reply; but, as seen in the present case, the parts in congenital dislocation accommodate themselves to the unusual circumstances, and in spite of the abnormal position of the femur the foot points straight forward. The considerable range of movement was mentioned as a fact opposed to the probability of a dislocation forwards; the existence of a hollow over the base of the Scarpa's triangle showed that the displacement could not be in this direction; and the head of the bone was readily felt to be displaced in a backward direction.

Regarding treatment, Mr. Jackson Clarke said that the suggestion of open operation in these cases had not been justified by results. Much, however, can be done by prolonged maintenance of the head of the bone in its proper position and by properly selected gymnastic exercises. It is all the more necessary to adopt these measures, as the condition is one which causes an increasing amount of discomfort as the patient reaches maturity. The lordosis becomes worse, and the patient often suffers much pain. In the present patient, a child of eight years, a perfect result cannot be promised, but undoubtedly the condition can be much improved, and when commenced sufficiently early, the treatment above-mentioned has almost invariably a most satisfactory issue.

A large Hæmorrhage at the Root of the Neck.

A young man, who a month previously had been seen with a large tumour at the root of the neck on the left side, was now shown

completely free from all sign of swelling and with the anatomical features of his cervical region perfectly normal. The tumour when first seen was tense and fixed, and was undoubtedly beneath the deep cervical fascia. It was said to have appeared suddenly. The thyroid gland appeared somewhat large, and the diagnosis of a hæmorrhage from the left lobe of the gland was suggested. The subsequent history may be quoted in support of this diagnosis. The patient said that he was very liable to bleeding at the nose on slight provocation, as for example when he washed his face. But there was no other personal or family incident to support the suspicion that the patient was the subject of the hæmorrhagic diathesis.

Cancer of the Breast.

A woman, 51 years of age, who had her left breast removed four years ago, now returned, with a painful nodule below the outer extremity of the scar, and with an enlarged gland in the left axilla. Mr. Clarke drew attention to the fact of the existence of a four years' interval between the operation and recurrence as bearing on the frequently advanced statement that non-recurrence within three years entitles a case to be claimed as cured. He then proceeded to discuss the measures which it would be proper to adopt in the case. In this connection he drew attention to an appreciable degree of fulness present above the left clavicle as a proof that the disease had involved the glands in this position, also to an enlargement at the junction of the manubrium and body of the sternum, and to the woman's complaint that she had begun to be troubled with "rheumatic" pains in her bones as facts of possibly sinister significance. As bearing upon the question of further operation was the suggestion of slow growth arising from the long period that had elapsed before recurrence. Taking all these facts together, it was urged that no extensive operative measures should be entertained. It was certain that the disease had passed above the clavicle, and there was some reason to believe that it was extensively diffused through the body. Hence whilst the painful nodule in the original scar might be removed, and also the gland in the axilla, nothing further in the way of operation should be undertaken. No advantage was to be obtained by extending the operation area to the

region above the clavicle, as the removal of the enlarged glands in that region would have no practical effect in staying the progress of the disease. In cases where such glands cause pain by pressure on the nerve trunks their removal is legitimate, but otherwise the more extreme operation is not justified. In reference to non-operative measures, Mr. Clarke stated that he had seen cases of malignant disease, more particularly in the neighbourhood of the mouth, definitely improve, at least for a time, under full doses of mercury and potassium iodide. Had the present patient been some years younger, he would have advised removal of the ovaries, but considering that she was over fifty, and that the ovaries must be functionally valueless, he would not recommend this step. Thyroid extract, he thought, ought certainly to be tried, but definite evidence of the value of X-rays and high frequency currents in the treatment of malignant disease had, he considered, still to be produced.

In connection with the subject of cancer of the breast, Mr. Clarke next discussed the proposal to remove the breast in cases of chronic interstitial mastitis on the ground that this condition was likely to prove the commencement of malignant disease. He admitted that time might prove this position to be correct, but he did not think it had yet been established. Considering that an undoubtedly cancerous process, namely, Paget's disease of the nipple, might be of so chronic a course as to extend over many years—he himself was familiar with an instance of six years' duration—it could not be denied that a process of interstitial mastitis might prove itself sooner or later to be of an essentially malignant character. But in his own experience he had not found this to be the case, and he was therefore not prepared to advise removal of the whole breast in cases of chronic interstitial mastitis. When cysts were present he would advise removal of a segment of the breast, and a careful examination of the removed tissue by the microscope. In the event of this proving negative in reference to malignant growth, no further operative measures are necessary, provided the patient is seen and carefully examined at frequent intervals. Should the enlargement fail to subside, or should other suspicious features appear, the position could be reconsidered, but at present, at all events, Mr. Clarke would not, in the light of his own experience, consider himself justified in proceeding to remove a

breast the subject of chronic interstitial mastitis. Several cases were related in support of this position. One of these also illustrated the difficulty of diagnosis which arises in some instances. The patient, a woman of 31 years, had a tense and uniformly enlarged breast, with all the characters of chronic interstitial mastitis. In addition, there was a sanguineous discharge from the nipple, a rare feature of diseases of the breast, and usually meaning a duct cancer. The breast, however, was uniformly enlarged, whereas duct cancer commonly presents itself as a localised mass set in the substance of the mammary gland. Microscopic examination of the discharge discovered the presence of cells containing cell-inclusions, often regarded as pathognomonic of cancer, though present also in other conditions. Thus the facts, though suspicious and suggestive, did not warrant an absolute diagnosis. Even when the patient was anæsthetised, and the breast incised, the appearances were not distinctive. For cysts containing cheesy-looking matter, such as were revealed by this means, may be found in several different conditions, such, for example, as tuberculous disease, syphilis, mastitis, &c., as well as in malignant disease. Here, however, the value of the microscope as an aid to diagnosis was illustrated, for it revealed numerous large, typical cancer cells. The operation was carried out on the lines indicated by this diagnosis.

DISEASES OF THE EYE.

BY E. TREACHER COLLINS, F.R.C.S.

Friday, July 11, 1902.

A Distended Frontal Sinus Displacing an Eye with a Cataractous and Dislocated Lens.

THOMAS N., aged 28 years. Twenty years ago this man received a blow on his left eye, and since that time the sight in it has been very defective. Six years ago he first noticed a swelling at the inner angle of the left orbit, and this has gradually increased in size.

He was admitted to the Moorfields Hospital on May 7 this year. His left eyeball was then seen to be proptosed and displaced downwards and outwards. At the upper and inner part of the orbit a fluctuating, elastic swelling could be felt, over the region of which there was no bony crackling. The left eye was much injected, the iris was tremulous, and lens cataractous. Vision = to counting fingers at 1 metre; tension normal. The position of the swelling and the displacement of the eyeball suggested distension of the frontal sinus; but the fluctuation and absence of any bony crackling made me inclined to think I had to deal with a dermoid cyst. Such cysts are sometimes met with at the inner angle of the orbit, though their most frequent seat is the outer angle. The day after patient's admission I made an incision through the skin over the swelling, and after cutting through a thick, stratified cyst wall, a large quantity of glairy, yellowish fluid escaped. The cyst was in communication with the frontal sinus on the left side, into which I passed my finger and found it enormously distended. I forced a communication between it and the nose, and along this I passed a lead wire, one extremity of the wire being left out at the external wound and the other out of the left nostril. A drainage tube was later substituted for the lead wire, and at the end of about six weeks all drainage was discontinued.

The eyeball, as you see now, is no longer inflamed, but it is still much proptosed and displaced down and out. Though the sinus now drains down into the nose, the distension of its bony walls still remains. In one way it is probably fortunate for the man that he has a cataractous condition of the lens, as otherwise he would probably be troubled with double vision. The cataract is probably the result of the injury of twenty years ago, when doubtless the suspensory ligament was ruptured, as is indicated by the tremulousness of the iris.

The obstruction to the infundibulum, which caused the distention of the sinus, probably also dated from the injury. In most of these cases a history of a blow, long antecedent to the manifestation of symptoms, can be elicited. The distension of the frontal sinus must have resulted in perforation of its bony walls and the formation of the elastic cyst which was felt external to it. The case illustrates the importance of being prepared to deal with a

distended frontal sinus whenever there is a swelling at the upper and inner part of the orbit, no matter what may appear to be the nature of its consistency on palpation.

Primary Chancre of the Eyelid, followed by Rash on Skin, without other symptoms.

Arthur C., a dock labourer, aged 33 years, first came under observation on June 23, 1902, stating that six weeks previously, while engaged in his work, he was struck on his left eye, and that since then a sore had appeared which had gradually got worse.

On the inner portion of his left upper lid an ulcerated surface was seen, with much induration around it, and having the appearance of a Hunterian sore. No definite enlargement of the pre-auricular gland, or of the glands at the angle of the jaw on the left side, could be detected. There was no rash on the skin, and no ulceration of the throat.

As the absence of any definite glandular enlargement made it doubtful if the sore on the lid was really a primary syphilitic lesion, some iodoform ointment was prescribed for application to it, and the patient instructed to attend from time to time for inspection.

With the use of the ointment the ulcer has to some extent healed; some induration around, however, still remains. No glandular enlargement has manifested itself, but on July 7 a slight copper-coloured rash made its appearance on the breast and right shoulder, and is still present.

Mr. Collins mentioned that the sore which sometimes results from the accidental inoculation of vaccine matter on the eyelid, often presents an indurated character very similar to that found with a primary chancre.

Night-blindness and Xerosis of the Ocular Conjunctiva.

A boy, aged 7 years, apparently well nourished, was brought by his mother, who complained that for the last fortnight he had been unable to see at night, and that he tumbled over things. On questioning, she admitted that he had been playing a good deal of late in the streets in the bright sunshine.

On examination of the eyes, there was seen a triangular patch on the ocular conjunctiva of each, outside the cornea and

opposite the palpebral aperture, which presented a white greasy appearance, and over which the tears did not seem to flow.

In a cover-glass preparation made from one of these patches the presence of the xerosis, or pseudo-diphtheritic bacillus, was demonstrated.

With the correction of some error of refraction the boy's faculty of vision appeared normal, and no changes were to be seen in either fundus.

It was pointed out that the presence of the bacilli in the xerotic patches was probably due to the fact that these formed a good medium for the bacilli to grow on, and that it was unlikely the micro-organisms had anything to do with the causation of the affection. It was also remarked that the night-blindness in this class of case, in contradistinction to that due to retinitis pigmentosa, is a recoverable affection. It is generally attributable to exposure to glare in improperly or badly nourished individuals, and is easily remedied by avoidance of bright light and by the administration of cod liver oil.

DISEASES OF THE NOSE AND THROAT.

BY STCLAIR THOMSON, M.D., F.R.C.S.

Friday, April 25, 1902.

A Case of Chancriform Ulcer of the Tonsil (Vincent's Angina).

THIS patient, a lad of 12 years, was the subject of a very unusual form of ulceration of the right tonsil. Apart from its rarity, the case had the practical importance of illustrating a condition which, if not identified, would almost certainly be diagnosed with confidence as syphilitic. The ulcer might readily have been regarded as a primary sore, or, had the patient been an adult might have been interpreted as a later result of syphilitic infection. It showed considerable excavation, with prominent, well-defined, somewhat uneven edges. The edge, though firm, had not however, the hard cartilaginous character found in cases of chancre. Further, though there was

some enlargement of the lymphatic glands, the enlargement was not so marked as is usual in chancre affecting the tonsil. It has been shown that this form of ulcer depends on a special kind of spirillum, a culture of which can be obtained from a scraping taken from the surface. The affection runs a subacute course, is attended with a mere slight elevation of temperature, and needs no treatment other than the use of a simple gargle. The patient complains of a sore throat and some difficulty in swallowing. On examination the ulcer is seen covered with greyish pultaceous material, and this being removed the deep excavated character of the sore is recognised.

A Case of Multiple Sinusitis.

This patient, a man aged 27 years, after many years of nasal discomfort, attended by considerable depreciation of his general health, had been cured by successive operations involving the maxillary, ethmoidal, and frontal sinuses. For at least six years before these operative measures were adopted the patient had on very many occasions polypi removed from his nose, each removal being soon followed by recurrence. When seen in November, 1901, it was observed that there was some distinct creamy yellow pus in the left nasal fossa, and this Dr. StClair Thomson regarded as a proof that one or more of the accessory sinuses was affected. It was subsequently found the maxillary, ethmoidal and frontal sinuses on the left side were each the seat of myxomatous degeneration affecting the mucous membrane, and it was only after each of these regions had been treated by a radical operation that the discharge of pus ceased. This local improvement had been attended by a general increase in the patient's mental and bodily vigour, the opportunities for pus absorption having been removed.

Other cases were—(1) a man with a specific ulcer destroying the ala and septum of the nose, and showing no response to anti-syphilitic treatment, (2) a case of laryngeal tuberculosis, (3) frontal sinus disease cured by operation, (4) a lad with cleft palate in whom through the cleft a mass of adenoids could be seen in the nasopharynx.

CORRESPONDENCE AND ANSWERS.

ARSENIC acid is less poisonous than arsenious acid. "It is said that those who are employed about it become very fat without any injury to their general health."

"In the year 1873, 5,449 tons of arsenic were produced in England (*"Encyclopædia Britannica"*). More than one-third of this came from one mine in Devonshire, where the arsenical pyrites are converted into white arsenic by roasting." Few sulphur ores are free from traces of arsenic. It is the most widely disseminated of all metallic elements. The arsenic of commerce, or white arsenic, is arsenious acid (anhydride).

* * *

USE OF ARSENIC IN THE EIGHTEENTH CENTURY.—In "A General History of Drugs," by Pimmet, dated 1748, we find the following:—"Arsenic is of some small use in physic, to perform some operations, as shall be seen hereafter; but chiefly made use of by dyers, and in the country to destroy rats and other vermin."

* * *

ARSENIC AND HERPES ZOSTER.—The best *resumé* of evidence as to the connection between arsenic and herpes zoster will be found in vol. ii., 143, of the New Sydenham Society's Library. It is by Dr. Nielsen, of Copenhagen.

* * *

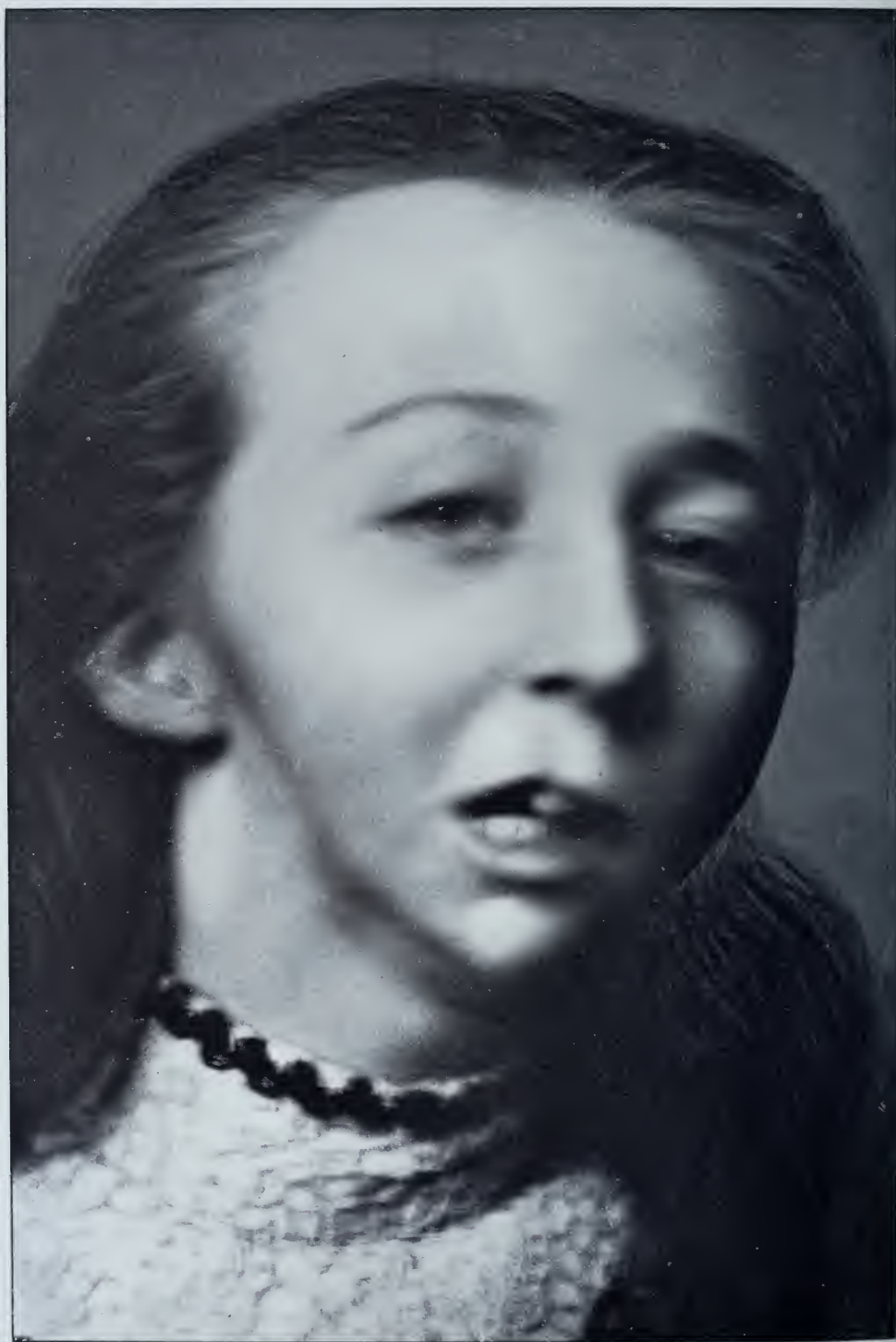
CIRCUMCISION AND ST. PAUL. — An energetic advocate of Circumcision (far West), records in an article in the *American Journal of Dermatology*, the following: "As an intelligent but irascible Scotch gentleman who had been raised in strict Scottish Presbyterian lines in his native land, and who had been brought up on oatmeal gruel, the Scriptures, and in a wholesome fear of the Lord, once expressed himself to me, after having been circumcised and convinced that much of his neurasthenia and resulting ill-health were all reflex conditions due to a tight prepuce: 'I have been brought up and educated to look upon Saint Paul, the founder of Christianity, with awe and admiration, but, by God, sir, if I had Saint Paul here now, sir, I would shoot him, yes, sir, I would shoot him. He had no biblical warrant nor no business to summarily abolish circumcision as he did. Our Lord was circumcised, so were the twelve apostles, even to that rascally Judas, and we should have all been circumcised instead of baptised. I see that very plainly now. Still Saint Paul was more of an evangelist and not as scientific a man as Moses, and I may be wrong in wanting to shoot him. He probably did not know the harm he was entailing on Gentile humanity by abolishing circumcision. Still, when I think of the agonies I have been made to suffer through his carelessness, I feel that he ought to be shot, sir.'"

* * *

T. B.—The parasitic cause of Porrigio or Impetigo contagiosa is the *Staphylococcus pyogenes aureus*, and perhaps also the *Staphylococcus albus*. It is said by some to be present almost universally in the atmosphere ready to infect any abraded surface.

* * *

"A GOUTY constitution is attended with great acuteness of parts, the nervous fibres of the brain and the other extremities being delicate."—"Arbuthnot," page 403.



*Facial hemiatrophy, the result of herpetiform morphea affecting the whole of the fifth nerve territory.
(See page 446.)*

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES' COLLEGE, LONDON.

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CANCER STATISTICS.

THE subject of Cancer is at present engaging the attention of the medical profession in many parts of the world. In collecting the statistical statements which we now offer to our readers we have availed ourselves of numerous elaborate Reports just issued in Prussia, New Zealand, the United States, and at home. Whilst well aware of the dangers which beset the attempt to deduce conclusions from statistics, we are yet very sanguine that important results will accrue from the kind of investigation which we now attempt. In this belief we invite our readers to the thoughtful consideration of the figures which we quote. They must not be regarded as for the present proving anything, but they may be very useful as finger-posts indicating the directions in which we may profitably work.

Death rates from cancer may be estimated in several different ways. The two principal ones are *first* the rate of deaths in proportion to the total number living of all ages, and *second* the proportion which deaths from cancer bear to other deaths. In further detail they may be estimated in relation to the numbers living of certain assigned ages.

the time of death would be considerably younger. In many cases in which operations do not wholly prevent death from cancer, they yet delay it for prolonged periods. These statements are especially applicable, perhaps, to some of the forms of external cancer in men. Few, indeed, now die of cancer of the lip, and probably not more than half of those in whom cancer shows itself on the tongue die of that malady, whilst in almost the whole of the other half several months, perhaps years, are added to the duration of life. Were there not counteracting causes at work, the mortality from cancer of the female breast ought to have diminished by a third, if not a half during the last quarter of a century. Of the cases saved from death by timely and complete operations, our statistics take no count, but no one familiar with the facts can hesitate to believe that they are very numerous. Even in the case of cancer of the uterus, and in other positions formerly deemed inaccessible, the same statements are, though, of course, with reduced force, still true.

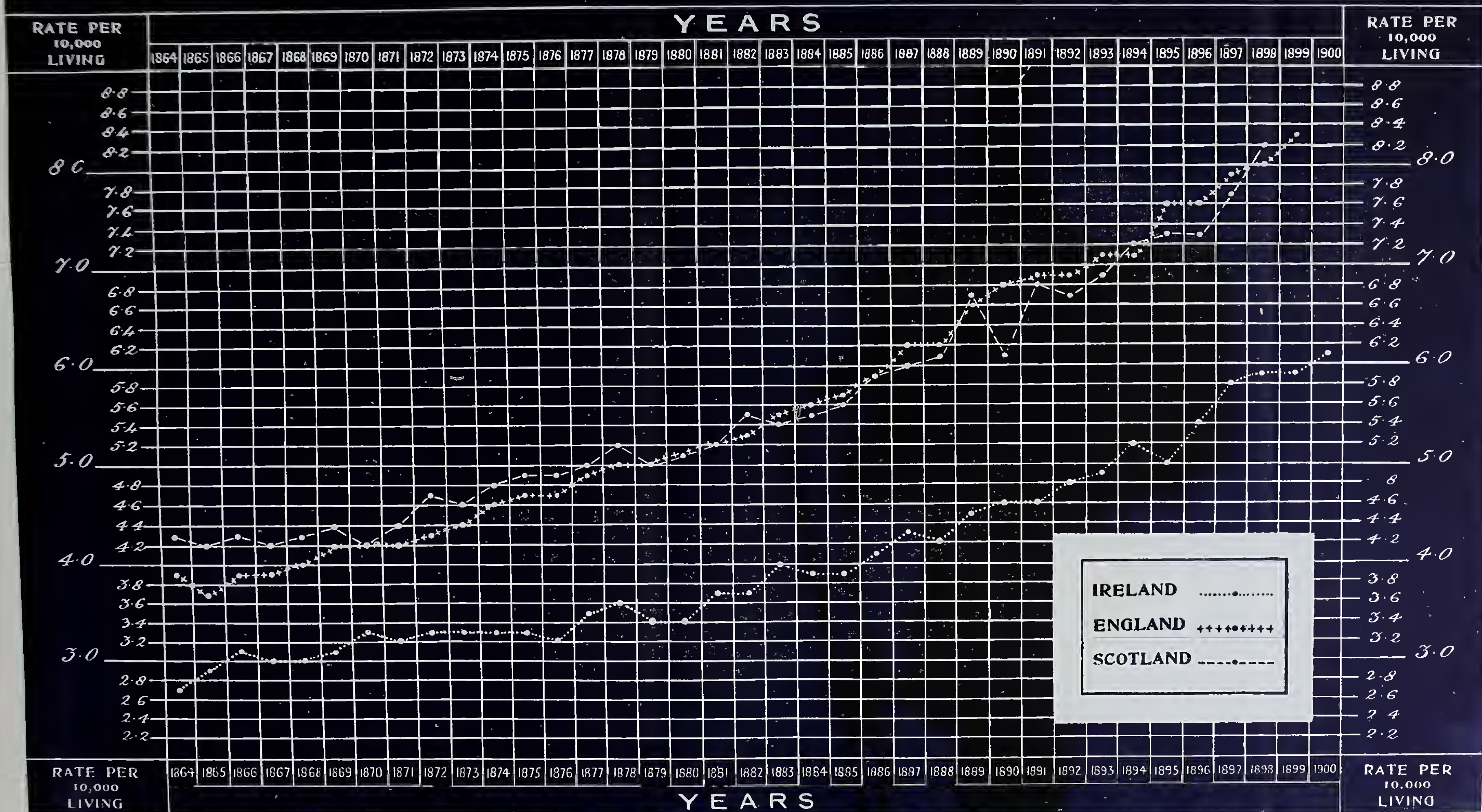
IRISH CANCER-STATISTICS.

THE death rate from cancer in Ireland is 6 per 10,000 of the estimated population; females are slightly but decidedly in excess of males (as 15 to 12). There is a definite annual increase, which during the year 1900 was greater amongst females than males.

The subjoined table, which we copy by permission of His Majesty's Stationery Office from the thirty-seventh Annual Report of the Registrar-General for Ireland, shows the rate of increase of cancer during the last thirty-seven years in England, Scotland, and Ireland respectively. It will be seen that the ratio of increase has been almost the same in the three kingdoms; briefly, the prevalence of the disease has almost doubled. It began at a lower level in Ireland and it still maintains a lower one. In England and in Scotland the prevalence and its increase have been almost exactly the same, respecting the latter a little to the disadvantage of England which began lower and has climbed a little higher.

Together with this Schedule, its compiler, Dr. Matheson, gives, in the very valuable report from which we take it, a Cancer Map for Ireland. We may, perhaps, at a future time, reproduce this

**DIAGRAM No. 4.—SHOWING THE DEATH-RATE FROM CANCER IN IRELAND. AS COMPARED
WITH ENGLAND AND SCOTLAND. DURING EACH OF THE THIRTY-SEVEN YEARS—1864-1900.**



map also, and comment upon it in some detail. For the present it must suffice to say that it shows that the disease is most common near to the great centres of population and least so in the distinctly rural districts. Dublin and Belfast suffer most, whilst the wilder regions in the south-west, with their exclusively peasant population, are comparatively exempt. A district around the town of Armagh (not far south of Belfast), appears to be emphatically a cancer-centre. Believers in the hereditary transmission of proclivity will see in this distribution the influence of race. Scandinavians and Teutons suffer, whilst Celts escape. Others, with Sir Mitchell Banks at their head, will trace the influence of meat-eating, and others yet may possibly suspect arsenicated beer and tobacco. Greatly to the advantage, probably both of public health and public morality, malt liquors have of late years tended to supersede whisky in popular consumption in Ireland. There has not, however, so far as we are aware, yet been obtained proof that any of the malt liquors in use in Ireland contain appreciable quantities of arsenic. Tobacco has not been examined. Apart from the vague conjectures which we have suggested, it is exceedingly difficult to give any plausible explanation either of the recent increase or the local incidence of cancer in Ireland.

[We have to express our obligation to Dr. Matheson, the Registrar-General of Deaths for Ireland, for most of the above facts.]

DOES ADVANCE IN AGE INCREASE THE LIABILITY TO CANCER?

IN the POLYCLINIC for June last we quoted a calculation from the Registrar-General's report which seemed to us to prove that the liability to cancer increases with age, and we even ventured to remark that this question ought now to be considered as set at rest. We were well aware that Sir George Humphry and some others had disputed this general belief, and had held that the human frame was more liable to produce cancer during the period immediately following middle life than in senility. A paragraph which occurs in Mr. Roger Williams' able treatise on "Diseases of the Breast," and which goes much beyond a mere expression of opinion, had, however, escaped our attention. After alluding to

Humphry's facts, and after giving a laborious citation of statistical evidence collected by himself, Mr. Williams writes as follows :—

“These facts clearly show that cancer is not a senile disease, and that senility *per se* plays no essential part in its development. The contrary belief is a mere myth, that by dint of continual repetition has gained wide-spread credence, without there being a particle of truth in it.”

Now it is certainly a matter to excite wonder that an observer so indefatigable as Mr. Williams should, dealing with precisely the same facts, have arrived at a conclusion so opposed to that of Dr. Tatham. Statistics are, indeed, untrustworthy if they can be made to support such contradictory statements. The question, however, is, do they really do so, or is not Mr. Williams at error in the mode in which he uses them.

Mr. Williams' method is to take the number of deaths occurring at different ages, and to count out the proportion caused by cancer. Thus he is able to show that during the two decades of 45 to 55, and 55 to 65, no fewer than one in every fourteen deaths was caused by cancer, whilst from 75 onwards only one in every forty-eight was so caused. This, however, is a wholly misleading way of stating the case. The question is, Are old people more prone to cancer? and the answer can only be given by estimating the proportion of deaths to the total number of those living at each age. When this is done, we find that during the decennium, 55 to 65, every thousand of those living supplied only 3·7 men, and 4·5 women, whilst during the decennium 75 to 85 onwards the ratio was 6·7 men, and 7·4 women. This is conclusive to the effect that the more advanced age is the one more liable to the disease. The asserted “myth” is not a myth at all, but a well-established fact. The pitfall into which Mr. Williams has fallen is forgetfulness of the fact that the proportion of deaths due to any one disease at any given age must always be in ratio with the liability of that period of life to other diseases. After the age of 65, other causes of death come into vigorous competition with cancer. A man's arteries may fail him, and he may die of apoplexy, or an attack of bronchitis which he would have thrown off in earlier life may easily prove fatal. After the age of 75, that unpreventable disease, old age, is upon him, and may probably not leave him the chance of developing cancer. By Mr. Williams' line of argument, it might not be difficult to show

that centenarians are wholly beyond the risk of malignant disease. It would, however, not be because their proneness to it had diminished, but because their dangers in other directions had so much multiplied.

We may, then, it is clear, continue to believe that youthful tissues, in full vigour of function and rapid in their processes of nutritional change, have in them that which tends to prevent their taking on cancerous processes of growth, and that tissues which are failing in such vigour are in far greater danger. Without dispute this danger sets in suddenly in the early senile period and soon reaches a point after which no leaps forward are taken; but there is no reason to believe that it ever recedes. After 65 the increment is only slow, but it is sure.

It is fundamental to all enquiries as to the predisposing causes of cancer that the facts as to the influence of senility, and what is now known as pre-senility, should be fully recognised. The creed of the profession, with very few exceptions, no doubt already recognises it, and were it not that Mr. Williams is an author upon whose labours we set a high value, and had it not been that he has asserted his conclusion on this point with so much emphasis and with such a specious citation of misleading evidence, we should not have thought it worth while to attempt his confutation.

THE LAWS OF INHERITANCE.

Is cancer hereditary? Is tuberculosis hereditary? Is leprosy hereditary? We have named three of the most important questions of the day. Regarding no one of them would our forefathers have made the least hesitation in their reply.¹ There has arisen, however, in these latter days a sceptical school which, partly from the difficulties of statistical proof, partly from the heresies of Weissman, and in part as the result of crude deduction from bacteriological discoveries, is inclined to discredit, or even to deny, the influence of inheritance, not only in respect to these maladies, but also some others on which it might have been thought that we were on firm ground.

¹ "Scirrhus, like Scrofula, is undoubtedly an hereditary malady."—COPLAND.

It is a little curious that this phase of belief should have followed so soon after the Darwinian teaching had seemed to open such a wide field for the opposite creed; but so it is. It might have been supposed that the acceptance of the Darwinian teaching would have led us to attach yet more importance to inherited predispositions of structure; and so, perhaps, they might, had it not been that doctrines of contagion have taken for the time such overpowering hold of the medical mind. The three maladies which we have named by no means stand on the same footing as regards inheritance. Tuberculosis and leprosy are probably very near to each other, and may possibly stand or fall together, since the doctrine which is gaining ground regards the latter as only a modification of the former. If it be so, the inherited proclivity to the one may involve that of the other, whilst it may remain quite possible that the peculiar features of leprosy may be dependent upon causes wholly distinct from inheritance. With cancer the case is quite different, for we have as yet no reason for the belief that it is attended by any organism which could by any possibility be conveyed by contagion, and much for the creed that mere senility and certain mineral poisons may each in turn become its efficient cause. One remark may, however, be made which is more or less applicable to all three diseases. It is that in estimating so-called statistical evidence far too much importance has been allowed to the negative side. The old story of the thief who tried to rebut the evidence of two witnesses who had seen him steal by producing ten who had not, is almost applicable here. The fact is that when a person denies a family history of tuberculosis or of cancer the statement is often of no more real value than that of the witnesses in question. To count such a statement as if it were of equal value on one side with an affirmative on the other is absurd. There is first the strong disposition which exists in many persons to refuse to recognise what they regard as a sort of family taint; next there is lack of knowledge; and lastly, lack of memory. It is but rare for the positive fact to be recorded in error, but in a large majority in which the negative is asserted it is either a concealment or a mistake. It is only reasonable, then, to attach importance almost solely to the positive facts. If they are weak let the case fall, but if they are strong, do not let them be outweighed by any number of mere negations. This remark

bears with especial force on the "statistics" collected by individuals from their own practice. So much depends upon individual preconceptions. The man who discredits inheritance will naturally take the first denial which his patient gives him, whilst the man who believes, and is in search of proof, will spend ten minutes in explanation and in cross-examination of relatives, and if he does not get at the truth on the first occasion, will revert to the question after there has been time for reflection and family enquiry. It is just the same in some minor matters, as, for instance, in determining the sequence of alopecia on ringworm and the association of gonorrhœal rheumatism with inherited gout. It is in each quite possible for one enquirer to find confirmatory evidence in almost all his cases, and another in scarcely any. The difference is in the bias of the enquirer, and the patience, or lack of it, which that bias induces.

The great difference in the character of what is called hereditary transmission in the case of syphilis as contrasted with gout has impressed many observers. Dr. Reginald Thompson in his able work on "Family Phthisis," page 136, suggests that the mode of transmission in syphilis ought to be called "parental infection." Hansen and Looft, discussing the transmission of leprosy, are anxious to draw the same distinction, and to use a similar expression.¹ Adopting what appears to us an arbitrary and a somewhat narrow definition of the word "heredity," they are wishful to deny that any specific (*i.e.* parasitic) disease can ever be "hereditary." This is to a considerable extent a question of words, but no one will dispute that the difference between the transference of specific germ-material from parent to child, and the transmission of a state of body giving predisposition to certain forms of disease is a very important one. We certainly ought to use terms not open to ambiguity. In the one case it is a sort of parental gift, in the other it is the taking over of an entailed estate. In the case of syphilis, it is highly probable that there is never anything more than mere gift from parent to child, and that nothing of the nature of atavism, or even of gift to the third generation, ever takes place. In tuberculosis and in leprosy, which in this matter go together, if it be conceded that the bacillus or its representative can pass with the

¹ It would be necessary to add antenatal, or it might be confused with communication after birth.

semen or exist in the ovum, then we know of no facts which would make it very improbable that such transference might be repeated in successive generations. All depends upon our creed as to the possibilities of the innocuous latency of bacilli. In 1895, Hansen and Looft wrote: "but we know of no phenomenon which would allow us to assume that the bacillus could occasionally become quite innocuous, and call forth *no* symptoms of disease." Since then we believe that Dr. Hansen has, in the light of new facts, much modified that opinion, and is prepared to admit that the bacillus lepræ is often quite innocuous, and exists in the tissues without producing any symptoms whatever.

What is true of leprosy is probably true with emphasis of tuberculosis, and it would, therefore, appear to be convenient to retain the term "inheritance" in reference to both. There can surely be no great difficulty in remembering clearly that there is a difference between the inheritance of specific germs and that of bodily habit.

The kind of inheritance which is chiefly to be supposed in cancer, is that of tissues predisposed to take on cancerous modes of growth. It is difficult to deny that the vital tendencies of the tissues differ somewhat in different individuals, and almost equally so to say that such peculiarities are not transmitted from parent to child. The existence of such peculiarities will make one individual more prone than another to develop cancer when appropriate local influences are brought to bear. These local influences may be partial suspension of the forces of nutrition, which functional inactivity involves, as in the case of the female breast; or the irritation of some mineral as in the case of arsenic.

The kind of facts which compel most practical surgeons to believe that proneness to cancer is inherited are those in which parent and offspring both suffer, or in which several members of the same family suffer. Such facts become stronger when some peculiar and exceptional form of malignant growth is concerned. This occurrence is sometimes illustrated in melanotic sarcoma. When a father and son both suffer from coal-black growths, the son beginning in boyhood, it is difficult not to suspect the transmission, not only of proclivity, but of actual germ-material. The same suspicion must occur when a boy of fourteen becomes the subject of rodent cancer of the face, his father having died of the same disease.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

SOME MISCONCEPTIONS REGARDING CERTAIN DISEASES OF THE LIVER.

BY W. HALE WHITE, M.D., F.R.C.P.

[*Abstract.*]

DR. HALE WHITE's lecture was mainly concerned with a critical examination of certain generally prevalent doctrines regarding various aspects of some of the organic affections of the liver, and with the presentation of clinical and pathological facts tending to show to what extent these doctrines require qualification. The several propositions which were discussed, and the arguments dealing with them, are presented in the following paragraphs:—

THE CAUSE OF CIRRHOSIS OF THE LIVER.

It is generally accepted that alcohol is the principal factor in the causation of hepatic cirrhosis, and the fact that in a large majority of cases—probably about 80 per cent.—there is a history of drinking freely or to excess, appears to afford a substantial foundation for the accuracy of this view. Yet there are good reasons for doubting the ability of alcohol *per se* to produce cirrhosis of the liver. In the first place, experimental administration of alcohol to various species of animals has always failed to cause cirrhosis. Secondly, while the use of alcohol is a widely-spread practice, the existence of cirrhosis does not, in the area of its distribution, correspond to this practice. For example, there is no reason to doubt that the use of alcohol is as free and abundant in Glasgow and Aberdeen as it is in London. Yet in the two former cities cirrhosis is an uncommon disease, whilst in London it is of relatively frequent occurrence.

Again, cirrhosis occurs occasionally in children, and though some of these cases may be due to alcohol, in others an alcoholic history is entirely wanting. These facts are sufficient to throw doubt on the truth of the doctrine that the agent which produces cirrhosis is alcohol. That alcoholic drinks used in excess lead to the development of cirrhosis of the liver is beyond dispute, but the ingredient essential for this purpose is much less certain. We must be content to allow that some factor of unknown nature complicates the problem. This factor may possibly be some constituent of alcoholic beverages not yet identified, and it may be that the prejudicial action of this unknown ingredient depends in some way on its association with alcohol. The position may thus be parallel to the peripheral neuritis which used to be attributed to alcohol until beer was shown frequently to contain arsenic. The safe statement in reference to the cause of cirrhosis is that the disease results from the use or abuse of alcoholic beverages, and that the efficient agent is some ingredient other than alcohol itself.

Another proposition may be advanced, namely, that cirrhosis in the clinical and pathological sense of the term never arises except in the circumstances just defined. This runs directly counter to the statements prevalent in text books, which give a long list of causes of the disease, including syphilis, malaria, perihepatitis, rickets, diabetes, lead-poisoning, scarlet fever, chronic heart disease, etc., etc. Now it may be allowed that some, or possibly all of these conditions are, or may be, accompanied by a general increase of the fibrous tissue of the liver as this is tested by microscopic examination. Further, in some cases, and more particularly in syphilitic disease, there may be in certain districts of the liver broad bands of fibrous tissue distorting and deforming the organ. But mere increase of fibrous tissue is not cirrhosis. Not one of the above conditions ever produces the symptoms of cirrhosis of the liver, and in none of them is the *post-mortem* appearance of the liver capable of being mistaken for cirrhosis by a pathologist of even modest experience. It is said that experimental obstruction of the bile-duct will in some animals cause a condition like cirrhosis. But it is certain that in man, though such obstruction is not uncommon, anything like cirrhosis in association with it is most exceptional. Thus for practical clinical purposes the so-called biliary cirrhosis

may be ignored. The conclusion of the whole matter is that, for the physician, cirrhosis of the liver has one cause and one cause only, namely, the administration of alcoholic drinks.

THE QUESTION OF HYPERTROPHIC *versus* ATROPHIC CIRRHOSIS.

It is frequent to find a distinction drawn between these two conditions on etiological, clinical, and pathological grounds. Any such distinction is, however, purely arbitrary and artificial. There is, no doubt, a very rare disease—Hanot's hypertrophic cirrhosis—seen usually in male children and attended by enlargement of the spleen, but, with this exception, hypertrophic and atrophic cirrhosis are merely different degrees or stages of one and the same disease, and any liver enlarged by cirrhosis will, if the patient lives sufficiently long, become small. The clinical and pathological characters upon which emphasis is laid as affording grounds for a differential diagnosis are merely the natural differences which obtain between the disease in its earlier and later stages. Whether the liver is enlarged or diminished in size, cirrhosis is one and the same disease, dependent on one and the same cause—the use or abuse of alcoholic drinks.

THE CAUSE OF ASCITES AND OTHER SYMPTOMS IN CIRRHOSIS OF THE LIVER.

There are reasons for doubting the frequently advanced statement that ascites in cirrhosis is due to pressure on the portal vein. Thus ligature of the portal vein in the lower animals does not cause ascites; obstruction of the vein by enlarged glands in the transverse fissure of the liver is common in cancer of the liver, yet ascites is an infrequent event in that disease; and the presence of ascites is not specially to be noted in those cases of cirrhosis in which *post-mortem* examination detects dilatation of the portal tributaries. The inference from these facts is strengthened by experiences in which ascites develops very rapidly—an occurrence very unlikely to be the result of gradually increasing pressure on the portal vein. It may, on the other hand, be suggested that the ascites is the result of a toxin in the blood, and that this irritates the peritoneum and so leads to the effusion of fluid. There are numerous other facts

in the symptomatology of cirrhosis of the liver which seem to support the suggestion that toxic influences play a large part in the natural history of the disease. The early jaundice, for example, cannot be due to pressure on the bile-ducts, but may be readily explained as a result of toxic action. Again, œdema of the feet may be present without any ascites; also when the liver is small; and with a normal condition of the superficial abdominal venous circulation. It cannot therefore be caused by venous obstruction, and its occasional absence when ascites is abundant supports this conclusion. But as one of the results of a general toxæmia its occurrence is easily understood. Even hæmatemesis and hæmorrhoids may be rather manifestations of a general tendency to hæmorrhage than results of obstruction to the portal circulation. Cirrhosis of the liver thus appears not as a local but as a general disease, and this view is strengthened by the fact that in a large proportion of autopsies in which cirrhosis in a pathological sense is discovered, there have been no symptoms of the disease during life. Something more than increase in the fibrous stroma of the liver is needed to produce the clinical picture of the disease. It may be conjectured that this something is a perversion of some internal secretion of the liver leading to a general toxæmia, and that the fibrous changes in the liver have a similar relationship to the symptoms of cirrhosis as have the pathological facts of granular kidney to the arterial and other degenerations of chronic Bright's disease. A further analogy is found in the association of fibrous atrophy of the pancreas with the clinical evidences of diabetes.

THE PROGNOSIS OF CIRRHOSIS OF THE LIVER.

In estimating the prognosis the occurrence of ascites is a fact of the first moment. Statistics give, in uncomplicated cirrhosis, an average duration of life of two months from the date when the patient first became conscious of the presence of ascites. It is, therefore, a symptom of very evil augury. The cases in which repeatedappings are followed by a more or less complete success are not cases of cirrhosis but are examples either of perihepatitis or of chronic peritonitis. In cirrhosis tapping may give relief when the breathing is hampered by pressure on the diaphragm, but it cannot delay, much less prevent, the fatal issue.

Dr. Hale White also discussed the clinical differences between primary and secondary malignant disease of the liver, and gave an account of the local effects on the liver and peritoneum which may be produced by the passage or impaction of gall-stones.

THE DIAGNOSIS AND TREATMENT OF SOME OF THE SUPERFICIAL AFFECTIONS OF THE EYE-BALL.

BY SIR ANDERSON CRITCHETT.

[*Abstract.*]

SIR ANDERSON CRITCHETT'S lecture comprised a detailed and graphic description of the various forms of conjunctivitis or ophthalmia, with suggestions to aid in their differential diagnosis and treatment.

In speaking of acute ophthalmia emphasis was laid on the fact that in this condition there is no manifest alteration in the quality of the secretion from the conjunctiva, and no change in the structural character of the conjunctival mucous membrane. The irritation may lead to an excessive flow from the lachrymal gland, and this fluid may have a somewhat scalding quality, but there is never any discharge of pus or mucus. Attention was drawn to the frequency with which an acute ophthalmia affecting one eye depends on the presence of a foreign body and to the necessity in these circumstances of a careful search for this, more especially below the upper lid and in the superficial tissues of the cornea. The methods of removing foreign bodies and the after-treatment of the eye were described, as also the dangers attending the introduction of escharotic substances, for example, lime, which calls for the use of a lotion consisting of vinegar and water. A decoction of marshmallow was recommended as a useful bland soothing lotion, suitable for use after removal of a foreign body from the conjunctiva or cornea and in many other conditions involving abnormal irritability. Regarding the treatment of acute ophthalmia generally, a warning was issued against the use of stimulating applications which, with a watery discharge, are always

contra-indicated. In young and vigorous patients cold evaporating lotions, or cold water applied to the lids by means of Leiter's tubes, are very useful, but in older patients hot fomentations, for example, a decoction of poppy-heads, are more grateful. If the inflammation persists, leeches may be applied to the outer orbital angle; blisters are only needed to relieve troublesome photophobia. Acute ophthalmia may pass into a subacute inflammation, or in asthenic patients the ophthalmia may be subacute from the commencement. The local conditions show a less vivid tint of injection and the conjunctiva has a darker red than in the acute variety; photophobia is often marked. Frequently this variety of ophthalmia is associated with anæmia and with a debilitated condition of the general health, due, for example, to menorrhagia or prolonged lactation. This is a fact of considerable moment, as treatment will hardly be successful unless the measures indicated by the state of the general health are put into operation. A generous diet, often including malt liquor and wines, is indicated, and should the ophthalmia display a disposition to recur, as it is apt to do, a change of air may be imperative. An opiate lotion may be prescribed as a suitable local measure.

Irritable ophthalmia is marked by slight injection of the conjunctiva, and light causes annoyance rather than distinct photophobia. There is no lachrymation, at the most a little froth is seen along the edges of the lids, due to the mixture of air with the secretion as a consequence of the frequent blinking movements of the eyelids. Rest is the principle which dominates the treatment. The eyes must be spared all near work and tinted glasses should be worn. A mixture of a drachm of the wine of opium with an ounce of rose water is a suitable lotion. When irritable ophthalmia becomes chronic, the explanation is usually found in the gouty diathesis, and evidences of this may be seen in the shape of small uratic deposits in the conjunctiva near the edges of the lids. These may be removed and soothing lotions, as those of boric acid, subacetate of lead, etc., may be ordered. Sometimes a solution of silver nitrate (2 or 3 grains to the ounce) is painted on the irritable parts near the margin of the lids, but this should never be left in unskilful hands. The functions of the bowels, kidneys, and skin all demand attention.

Phlyctenular ophthalmia is usually seen in strumous children. It is characterised by the production of one or more phlyctenules.

The phlyctenule is seen first as a minute red eminence, usually situated close to the corneal margin, and to it a brush of highly injected vessels pass. Later, the surface has a grayish appearance, and superficial ulceration occurs. One of the clinical features of phlyctenular ophthalmia is photophobia out of all proportion to the size and extent of the lesion. The treatment demands careful regulation of the child's diet, the avoidance of sweets, condiments, etc., and the use of plain but nourishing food. In mild cases calomel should be dusted on the conjunctiva, in more severe ones an ointment (1 to 10 grains to the ounce) of yellow oxide of mercury is more suitable, whilst with excessive photophobia poppy fomentations, and blisters to the temple, are indicated. Not very infrequently the disease is complicated with a discharge from the nostrils and an eczematous condition of the lips and face; in these circumstances arsenic in combination with a mild alkali should be prescribed for internal medication. Phlyctenular ophthalmia is apt to develop after an attack of measles and is then sometimes very obstinate. A change to the seaside is an effective form of treatment.

Catarrhal ophthalmia begins with injection of the lids. There is excessive secretion, which is altered in quality and causes the lids to adhere when closed during sleep. It is distinguished from all other varieties of ophthalmia by the fact that it is not accompanied by intolerance of light. Thus the patient does not shrink even from a brilliant illumination. The secretion is apt to smear the cornea which thus has a dull appearance. For the same reason the patient's vision is often somewhat deficient in acuteness. A third consequence is that halos, or rings of light and colour, are seen round the flame of a candle, lamp, or gas jet, and this often causes some alarm. The disease appears to be due to some peculiar condition of the atmosphere, and it also spreads by local contagion. Hence epidemics of it occur in schools, workhouses, etc., and these demand very energetic supervision of the sanitary arrangements, as well as precautions against direct personal infection. If continued, catarrhal ophthalmia tends to produce a velvety thickening of the lids—the so-called papillary granulations. The treatment is the use of local stimulants, as silver nitrate (1 to 2 grains to ʒi.), zinc chloride (1 grain to ʒi.), protargol (10 per cent), alum, lapis divinus, etc.

The concluding portion of the lecture was occupied by a descrip-

tion of the clinical characters and treatment of purulent ophthalmia. Allusion was made to the rapid and destructive character of this disease as it occurs in adults in tropical climates, also to the tendency of the disease to lead to granular ophthalmia, pannus, etc. The treatment of these conditions by inoculation and by peritomy was discussed, and some remarks were made on the purulent ophthalmia of the newly-born.

LEPROSY IN THE PACIFIC ARCHIPELAGO.—The following is extracted from a letter from a missionary in the Pacific and was written in 1877. It refers to a small island visited by the missionary vessel :—

“ Raratonga, South Pacific,

“ July 24, 1877.

“ MY DEAR SIR,

“ I have just returned from a voyage of inspection, touching at an island called Bukapuka, 600 miles to the N.W. I once told you that leprosy had been introduced into this island from the Sandwich Islands. You denied its infectious character and your view seems to be borne out by the fact that only four cases remain now on Bukapuka. Several have died; some have recovered and that without medicine. For five months the little community had not seen a sail until our vessel touched there. There, if anywhere, the disease might have run riot, but it is nearly extinct. No white person lives on Bukapuka, so the poor people there have had no external aid whatever.—Yours faithfully, W. W. S.”

It would be of great interest if further information could be obtained as to this island. Our correspondent's statements may have a little *couleur de rose* in them, and it is quite possible that his original impressions as to the extent of prevalence of leprosy were exaggerated. Everything which concerns the history of leprosy in the Pacific archipelago is, however, of great interest. It has been asserted on French authority that the disease is indigenous on all these islands, but if so it has certainly prevailed much more extensively on some than on others.

It may be noted that whilst leprosy was thus dying out in an island where the natives were left to themselves it was increasing in the Sandwich Islands where segregation was enforced. At Bukapuka the salting of fish was possibly unknown, whilst at Honolulu the trade was vigorous, and salted salmon was actually supplied to the leper homes. In the year 1889 (the report for which is before us) twenty barrels of salt salmon, at a cost of nearly £300, were supplied to the leprosy settlements at Kalawao alone, at which place a very heavy mortality prevailed.—(J.H.)

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY C. THEODORE WILLIAMS, M.D., F.R.C.P.

Tuesday, July 1, 1902.

A Case of Movable Kidney.

THE patient, a woman of 59 years, was sent by Dr. McCrae. The facts were easily demonstrated, and the diagnosis was in no sense doubtful. The right kidney had a very free excursion under bimanual palpation, and after replacement in its normal position could be felt to be pushed downwards on the descent of the diaphragm in deep inspiration. There was also some undue mobility of the left kidney. Dr. Williams described the characters of the movable kidney as an abdominal tumour and discussed its diagnosis from impacted fæces, enlargement of the liver, and ovarian tumour. He laid special stress on the change of position produced by alterations in the patient's decubitus and by manipulation. In reference to symptoms, he pointed out that in some instances movable kidney produces no ill effects and is only discovered in the course of a chance physical examination. In others, in consequence of pressure on nerves, it causes much pain. In a third group the symptoms are those of disordered digestion. It is very rare indeed to find hæmaturia or other signs of renal disorder. Treatment, in those cases where there is discomfort, can only be mechanical. Attempts to keep the organ in its proper position by means of a pad and an abdominal bandage are sometimes successful, but in most instances complete cure can only be effected by surgical measures.

Hæmaturia due to the Bilharzia Hæmatobia.

This patient, a man of 26 years, was under the care of Dr. Gabe, and the diagnosis was made by Captain Hayward Pinch. The history of hæmaturia extended over some five years. It commenced after a series of malarial attacks from which the patient suffered when serving as a soldier in South Africa. The only other symptom was pain below the left scapula, and this was of recent origin. Various attempts had been made to explain the hæmaturia, and the patient had been examined for stone, but with negative results. On microscopic examination of the urinary deposit Captain Pinch detected the ova of the *Bilharzia hæmatobia* and thus established the diagnosis. The following statement on treatment is from Dr. Guille-mard's article in Clifford Allbutt's *System of Medicine*: "The chief aim will be to sustain the patient's strength and to combat symptoms. When it is considered that the chief seat of the parasite is in the portal vein, the utter uselessness of medicated injections of the bladder, recommended by some physicians, needs no demonstration. They have, moreover, in some cases proved extremely harmful. Dr. Fouquet, of Cairo, claims to have had success with the ethereal extract of male fern, which perhaps might be tried, but until some diffusible anthelmintic be discovered powerful enough to destroy hæmatozoa without injuring the host, little can be done. Free diluents may be used with advantage, a non-stimulating diet recommended, and a watch kept for symptoms of calculus."

A Case of Bronchiectasis.

The characteristic physical facts of bronchiectasis were demonstrated in a boy of 15 years. In addition, the patient showed extreme "clubbing" of the tips of the fingers which Dr. Williams described as a not infrequent result of both bronchiectasis and chronic empyema. Attention was drawn to the characters of the expectoration, more particularly to the peculiar faint odour, and this was contrasted with the extremely offensive character of the expectoration in cases of pulmonary gangrene and of abscess of the lung.

Mitral Disease in a Boy.

The history included several attacks of rheumatic fever, and examination of the chest detected the physical signs of mitral regurgitation with considerable hypertrophy of the left ventricle. In speaking of the prognosis Dr. Williams said this was not necessarily a bad one. Provided the boy can live under favourable conditions he may enjoy many years of life without any very serious inconvenience. Compensation is now perfect, and this may be maintained if no unusual strain is placed on the cardio-vascular apparatus. Dr. Williams stated that he had seen not a few cases of organic heart disease in children, in which, when adult life was reached, the murmurs had completely disappeared. There was in the present patient one qualifying consideration, that is, the possibility of pericardial adhesion. The widely diffused pulsation in the pericardial region, with some appearance of retraction of the intercostal spaces during the systole of the ventricles, suggested the existence of this complication and so far increased the gravity of the prognosis.

Other patients included (1) a case of phthisis pulmonalis with signs of cavity and of emphysema, and (2) a patient with pain in the head regarded as due to intra-cranial disease.

BY SEYMOUR TAYLOR, M.D., F.R.C.P.

Tuesday, July 8, 1902.

A Case of Scurvy-Rickets.

THE patient was a child of 2 years and 9 months under the care of Dr. O'Bryen, of Sydenham, who kindly sent the case for demonstration. The history showed that the boy had been in all respects vigorous and healthy until some three months ago, when, according to the mother's account, he had a fall after which "he went off his feet." This had been followed by loss of flesh, general failure of health, and pains in some of the joints of the lower limbs.

Examination showed the usual evidences of rickets, more particularly the enlargement of the epiphyses of the long bones. Pressure over various bones caused the boy to cry, and he also resented movement. In addition, the gums were spongy, tender, and of a purplish hue. There were no hæmorrhages to be seen, either in the skin or elsewhere. For the most part the child had been fed on milk and starchy foods. In discussing the case Dr. Seymour Taylor remarked on the union of the two diseases—scurvy and rickets—producing so decided a clinical type as to merit a new or separate nosological position. The principal features in the present case were those of rickets. In others the symptoms of scurvy predominate, as, for example, hæmorrhages. These may be in the skin, mucous membranes, or viscera, but they especially tend to occur below the periosteum and more particularly in the lower limbs. The tenderness of the muscles and bones, and the objection to movement, were also insisted on as features in the diagnosis.

The prognosis is either extremely good or very bad. The patients either make a complete recovery, or they get progressively weaker and die. The treatment is for the most part a question of diet. This must contain meat juices or raw meat pulp; fats, as cream, butter, or beef-dripping; and fresh vegetable juices, as lemon or orange-juice.

Hæmaturia due to Bilharzia Hæmatobia.

A case of this nature will also be found reported on page 426. In the present instance the patient was a man, aged 24 years, who had been engaged as a soldier in the South African War. His sole complaint was the presence of blood in the urine, and this was more particularly noticed during the latter part of micturition. At no time had there been pain, and, excepting some degree of anæmia, physical examination gave negative results. Dr. Seymour Taylor remarked that the greater amount of blood being towards the end of micturition, and the blood being bright red in colour, were facts suggesting the bladder as the source of the hæmorrhage. He advised that microscopic examination of the urine should precede any exploration of the bladder by a sound, particularly as the entire absence of pain was opposed to calculus as the cause of the

hæmorrhage. When this was done the characteristic ova of the parasite were at once detected.

A Case of Elephantoid Edema of the Lower Limbs.

The patient was a man of 28 years. The lower limbs below the knees presented coarse thickening of the integuments. There was a history of recurring attacks of erythema followed by desquamation. It was suggested that in these cases there exists a phlebitis with plugging of the veins, and also obstruction of the lymphatics in the neighbourhood of the veins as a result of extension of the inflammation. Mr. Hitchins, who also examined the case, drew attention to the existence of fissures and other breaches of surface on and between the toes as possible avenues through which septic absorption might occur.

BY J. EDWARD SQUIRE, M.D., M.R.C.P.

Tuesday, July 15, 1902.

A Case of Pneumothorax.

IN our issue of May last (p. 244) we reported a case of pneumothorax the chief interest of which resided in the fact that the cause of the condition was quite obscure. The present was an almost exactly parallel case. The patient was a man of 45 years and entirely free from any history throwing suspicion upon the soundness of his respiratory apparatus. Yet about a month ago he suddenly awoke one night to find himself suffering from an urgent degree of breathlessness, and when examined directly afterwards by his medical attendant the clinical evidences of pneumothorax were readily detected. At no time has the patient suffered from cough, dyspnoea, pain in the chest, or other symptom suggesting pulmonary disease, nor is there anything in his personal or family history to introduce a suspicion of tubercle. It is noteworthy that the pneumothorax developed when the patient was sleeping. In Mr. Douglas Wright's case, too, the patient was in bed when the breathlessness developed (see p. 245), though some slender excuse might possibly be found in this instance in the fact that the occurrence of the pneumothorax

coincided with some effort or strain on the patient's part. But in the case now recorded there was absolutely no provocation of this sort. The patient, in fact, was aroused from his sleep by a sense of urgent breathlessness. Thus it would be impossible to imagine a clearer case of pneumothorax developing apart from strain or effort and in a patient free from history and evidence of pulmonary disease. Dr. Squire, in discussing the case, described the occurrence of pneumothorax in a patient the subject of chronic bronchitis who was at the time engaged in dumb-bell exercise. Here, presumably, some emphysematous air-vesicles ruptured under strain, the rent also involving the pulmonary pleura. The pneumothorax was followed by a suppurative pleurisy, due doubtless to the introduction of septic material carried by the air into the pleural cavity. This is not a frequent event in cases of what may be called "simple pneumothorax." The more usual course is for the air to become gradually absorbed. That possibility was illustrated by the case now reported. Since the commencement of his illness, fully a month ago, the patient has gradually improved and can now take a moderate amount of walking exercise without discomfort. Though the physical examination of the right chest still betrays the presence of air in the right pleural cavity, the amount of the air is not extreme, and there are some suggestions of re-expansion of the lung. There has been no active treatment, and all that can be done is to wait patiently whilst the natural mode of cure progresses to a more complete result.

Cases of Tachycardia.

The first of these was an example of Graves' disease. In addition to the rapid action of the heart there were both exophthalmus and enlargement of the thyroid. Dr. Squire advised the administration of thyroid extract. He pointed out that the action of the remedy needed careful observation, as in some instances it aggravated rather than improved the symptoms of the disease. In two other patients, both men in advanced middle life, there were no evidences of organic disease, and it was concluded in each case that the disturbance of the heart's action was the consequence of dyspepsia.

Recovery from Acute Pulmonary Tuberculosis.

The patient, a girl of 14 years, was admitted to hospital some three months ago with a history of recent cough and rapid loss of flesh. There were widely distributed physical signs of pulmonary disease, including scattered bubbling rales; tubercle bacilli were abundant in the sputa; and the temperature had the intermittent character seen in cases of mixed infection. To all this the girl's present condition affords a striking contrast. She is free from cough and looks well nourished, having gained nearly two stones in weight; expectoration has ceased; and physical examination of the chest fails to detect any signs of active disease. Dr. Squire drew particular attention to the fact that whilst the girl is 14 years of age she has never menstruated. He expressed the opinion that this circumstance had much to do with the favourable result. In cases where the development of pulmonary tubercle coincides with the establishment of menstruation, the prognosis as a rule is very bad. The natural strain on the organism produced by the emergence of the functions associated with puberty leaves a diminished degree of vital force to resist the attack of the bacilli. But when menstruation has never occurred, it may be presumed that the reserve force accumulated in view of this event may be utilised for the purpose of increasing the resisting capacity of the tissues. When tubercle appears about the age of puberty, therefore, the prognosis in any given case is much influenced by the consideration whether definite evidences of puberty have or have not appeared.

BY. C. O. HAWTHORNE, M.D., M.R.C.P.

(Continued from page 397.)

A Case of Infantile Paralysis.

THIS is an example of an entirely different type of paralysis from the case we have just discussed. The patient is three years of age, and you see he limps slightly when he walks. The defect is manifestly in his right lower limb. When we examine him we find that the muscles of the right leg are much less bulky than the corre-

sponding muscles of the left limb, and they feel somewhat soft and flabby. The right foot is distinctly smaller than the left, and the length of the right limb is about half an inch less than the left. Instead, therefore, of the paresis and rigidity which distinguished the first case, we have here paresis and atrophy. Some twelve months ago the boy was kept in bed for a few days with an attack of "bronchitis," and when he got up it was found he had scarcely any power over his right lower limb. In a very short time the muscles showed considerable wasting. Now, you observe, the atrophy is limited to the muscles below the knee, and even these are improving and already possess such an amount of power that the boy's gait is only slightly hampered. The case is obviously one of infantile paralysis, and it illustrates very well how in this disease a fairly widespread paralysis at the outset becomes later on more restricted in area. That is no doubt the usual tendency of the disease. But we must give some credit to the persevering use of electricity and massage, which have at least maintained the vitality of the muscles and promoted their development. The improvement so far is very satisfactory, but I hope we may yet see it increased. The limb probably will never be perfect, but we may perhaps prevent any serious degree of lameness.

There is one other fact which may be noted. It is the presence of the knee-jerk in the affected as well as in the healthy limb. In many cases of infantile paralysis the knee-jerk no doubt is lost, because the lesion in the spinal cord extends to the level of the nerve centre commanding the reflex arc on the integrity of which the jerk depends. But if the lesion does not involve that level, the knee-jerk remains unaffected. This is the case in our patient. The permanent changes in the spinal cord obviously affect the centres on which the efficiency and nutrition of the muscles in the distal part of the limb depend, but they do not extend upwards so far as to affect the condition of the thigh muscles. Hence the retention of the knee-jerk.

A Case of Pseudo-hypertrophic Paralysis.

This boy is yet another example of paresis of the lower limbs in early childhood, and his case belongs to a different group from that

occupied by either of the two previous patients. As he stands, you notice, he keeps his feet widely apart, and there is marked lordosis, with considerable prominence of the belly. In walking he drags his limbs somewhat, and there is a decided waddle in his gait. His calves are so large that he has to get special socks made for him. But the muscles here are weak, for when I tempt him to reach a penny held above his head he is unable to rise on his toes, and if you handle the calves you at once recognise that the sensation is not that afforded by healthy muscle. On the contrary, they have a hard, inelastic, wooden quality. In the upper limbs there is a general poor development of the muscles which pass from the shoulder-girdle to the humerus, and the weakness of these is manifest, for when I hold the boy up by his armpits he can offer such slight resistance that his shoulders go up almost to his ears. The case is obviously one of pseudo-hypertrophic paralysis, and if anything were wanting to complete the diagnosis, it is afforded by the distinctive manner in which the lad rises from the recumbent to the erect posture. The knee-jerks are present. Pseudo-hypertrophic paralysis is a disease of the muscles, not of the nervous system, and the state of the knee-jerk is entirely dependent on the involvement or non-involvement of the quadriceps muscle. As in this case the extensor muscles of the thigh are healthy, the knee-jerk remains. There is a complication in this case which is not infrequent in pseudo-hypertrophic paralysis. The boy has chronic disease, doubtless tubercular, of his right lung. The physical signs in the right infraclavicular region show the presence of a cavity, and the fibrotic changes in the lung have drawn the heart over into the right chest. This condition of *dextrocardia* is very conspicuous, for you can see and feel the cardiac impulse close to the right nipple, and the heart sounds here are very loud, whereas in the precordial region there is no impulse and the sounds are comparatively indistinct. In spite of this serious complication the boy looks well and is quite a merry little fellow. When he first came to the hospital more than two years ago—he is now six years of age—he could not walk, and he never had walked. His relatively satisfactory condition is mainly due to the care which his mother has bestowed upon him. He is most carefully protected from cold and fatigue, and is well and judiciously fed. A very important feature in the treatment is the encouragement of the lad

to use his limbs, and as you see, he now walks fairly well. In addition, massage and passive movements are practised. We cannot hope to give him healthy muscles, but by the above measures, supplemented by cod-liver oil, etc., we are doing something to increase the range of his activities and to prolong his life.

SUPPLEMENTARY REMARKS ON THE ABOVE CASES.

These three cases have one feature in common, viz., motor paralysis without sensory defect. In each instance, therefore, there must be a lesion in the motor pathway, and limited to the motor pathway. That pathway may be said to consist of three divisions. The first commences in the motor centres of the Rolandic area of the cortex and is continued downwards through the internal capsule and base of the brain into the crossed pyramidal tract as this descends in the lateral column of the spinal cord. This is the upper or cerebro-spinal segment of the motor tract. The second division is formed by the nerve-cells in the anterior cornua of the spinal cord and by the nerve fibres which issue through the anterior roots of the spinal nerves to be continued in the peripheral nerves to the muscles. This forms the lower or spino-muscular segment. The third division of the motor pathway is formed by the muscles themselves. In any case of paralysis the lesion must necessarily be situated in one or other part of the above-defined apparatus. Now it happens that in the three cases we have examined this afternoon we have an example of a lesion in each of the three divisions of the motor mechanism, and it may be convenient to briefly set forth the reasons which enable us to make the anatomical diagnosis in one division rather than the other. The ability to do this depends on an appreciation of the functions of the several parts. And the key to the position is provided by recalling the fact that the nerve-cells of the anterior cornua have, in addition to discharging motor impulses under the stimulus of impressions reaching them from the upper segment, two additional functions. In the first place, they have a trophic function, that is, they are active agents in promoting the nutrition of the muscles and, indeed, of the tissues generally. In the second place, they are reflex centres. Now a lesion in the upper segment will leave the spinal centres still active. Hence, while it

will produce paralysis, it will not remove either the trophic or reflex influence of the spinal centres. Indeed, it would appear that the cerebral centres normally exercise some degree of control over the reflex activity of the spinal centres, and when this is interrupted, as by degeneration in the upper segment, we get exaggerated action of the spinal centres, and consequently, tonic spasm of the muscles, with increased knee-jerks and the presence of ankle clonus. On the other hand, a lesion in the lower segment will, in addition to paralysis, cause loss of both trophic and reflex influence. Hence, in this case, we get rapid wasting of muscles and also another sign of nutritive change, namely, an alteration in the electrical reactions of the muscles, and more particularly the reaction of degeneration; there will also be diminution or loss of the tendon phenomena. Therefore, to put broadly the contrast between a lesion of the upper and one of the lower motor segment, we have in the first paresis, muscular rigidity, exaggerated tendon phenomena, muscular wasting only to such a degree as may be accounted for by disuse, and no electrical change, or at least no reaction of degeneration. In the case of the lower motor segment we find paresis, muscular flaccidity, loss of the tendon phenomena, rapid and extreme wasting of the paralysed muscles, and the development of the reaction of degeneration. The knee-jerk, as in our second patient, is not lost if the lesion does not involve the level of the reflex arc on which the jerk depends; hence we may say that in lesions of the lower motor segment the jerk may be absent or present, but it is never exaggerated. It is these considerations which enable us, in the case of spastic paraplegia, to refer the lesion to the upper or cerebro-spinal segment, and in the case of infantile paralysis to localise the lesion in the lower or spino-muscular segment. In the case of pseudo-hypertrophic paralysis we have to deal, not with a nervous, but with a muscular defect. The disease is a myopathy, not a neuropathy. It depends upon some inherent defect of certain muscles to sustain themselves at a level of healthy vigour. The circumstances which guide us in concluding that a given case of paresis belongs to the myopathies are as follows: The disease commences in childhood, or rarely, as late as the development of puberty; several members of the family may be affected, though there are exceptions to this rule, and the case we have seen to-day is such an exception; the condition comes

on gradually, weakness and atrophy—or atrophy in some muscles with pseudo-hypertrophy in others—developing *pari passu*; the disease is especially seen in certain groups of muscles, of which the calves, thighs, buttocks, and muscles of the shoulder-girdle may be mentioned—in one variety some of the face muscles are attacked; the electrical reactions of the muscles may be diminished, but there is no reaction of degeneration, at least not until wasting is extreme; the tendon-jerks are lost if the muscles on which they depend are affected; otherwise they remain, but they are never exaggerated. Most of these statements apply to our third patient, and therefore we localise the lesion in his case, not in the nerve tracts, but in the terminal division of the motor apparatus—that is, in the muscles themselves.

SURGICAL CASES.

BY J. JACKSON CLARKE, F.R.C.S.

Wednesday, July 2, 1902.

A Case of Chronic Cystitis.

THE history of this patient, a man of 41 years, was related by Dr. Gabe. The most important symptoms had been frequent micturition—which had been present during the night as well as during the day—and pain at the point of the penis. These had been troublesome for ten months and had been attended by a general failure of health and strength. At no time had blood been present in the urine. Examination of the urine showed an abundant whitish deposit, which under the microscope was seen to consist of pus. The bladder appeared to be distended, as the hypogastrium was dull to percussion, and *per rectum* the prostate was found enlarged with backward bulging of the bladder so as to form a post-prostatic pouch. Commenting on the case, Mr. Jackson Clarke described the condition as a very serious one. Apart from the risk of extension of septic and suppurative processes upwards along the ureter so as to involve the kidney, there was the fact that in his

present condition the patient was undoubtedly the subject of septic intoxication. His pinched, anxious appearance suggested this, and his temperature chart would almost certainly show a marked evening elevation. The explanation is to be found in the retention of pus in the pouch of the bladder formed behind the enlarged prostate. Such an anatomical development prevents effective drainage of the bladder *per urethram*. The pus found in the urine is merely the surface overflow of the much larger amount which remains undisturbed in the post-prostatic pouch. Just as this collection of pus escapes the flow of the urine, it will also escape the flow of a stream of fluid introduced with a view to wash out the bladder. Further, this last-mentioned proceeding would involve the passage of a catheter and the very grave risk of urinary or catheter fever. Indeed, it is to be remembered that the one thing that ought *not* to be done in these cases is to pass a catheter. Yet the necessity remains to drain the bladder, and to accomplish this with as little disturbance as possible; for it is certain that the patient is not in a condition to submit to severe operative measures. Mr. Clarke therefore advised that the bladder should be drained through a perineal opening. This would secure proper and efficient drainage. The operation can be performed quickly and without risk of hæmorrhage, and the incision can be utilised at a later date for the removal of the prostate, should this be deemed advisable. For these reasons Mr. Clarke urged the perineal route rather than drainage through a suprapubic opening.

A Chronic Tuberculous Gland.

This patient, a man of 40 years, had a considerable enlargement of one of the upper cervical lymphatic glands. On the same side, too, he had several highly carious teeth. Mr. Clarke expressed the opinion that the gland was tuberculous, and that the teeth had probably formed an avenue for the entrance of the tubercle bacilli. He therefore advised the removal of the teeth and the excision of the gland.

BY W. JOHNSON SMITH, F.R.C.S.

Wednesday, July 23, 1902.

Simple Fracture of the Metatarsal Bones.

A skiagram was presented very clearly showing united fractures of the shafts of all the metatarsal bones of the right foot. The subject of this case—a big muscular seaman—had been thrown down and carried along the deck of his ship by a “heavy sea,” and the injured foot had, he thought, been struck by a floating spar or some other heavy body. Although the foot was much swollen and remained very painful after the receipt of injury, the man did not keep to his bed, but endeavoured to discharge his duties as well as he could until the end of the voyage. When the patient was first seen at the Seamen’s Hospital about five months later, his right foot was shorter than the other but was much increased in extent from side to side. The soft parts of the dorsum of the foot and the lower third of the leg were swollen. The skiagram showed a fracture of the shaft of each metatarsal bone from the first to the fifth, with much displacement of the fragments. The case was regarded as one of some interest from the very rare occurrence of such extensive injury of the metatarsus without wounding and open contusion of the soft parts. Simple fracture of the fifth metatarsal from indirect violence, as has recently been proved by Mr. Jones, of Liverpool, is really a common injury, but fracture from direct violence of two or more metatarsal bones without laceration of the skin and free exposure of the fragments must, it was held, be very exceptional.

Deformity of Foot resulting from Comminution and Partial Removal of Calcaneum.

In this case nearly the whole of the calcaneum had been destroyed eighteen months previously, as the result of a bad compound and comminuted fracture caused by the fall of a torpedo on to the back of the foot. The injured foot was fixed in the position of talipes equinus and almost in a straight line with the leg, the man walking on the heads of the metatarsal bones and the toes. Some difficulty

had been experienced in this case in closing a wide granulating surface at the back of the ankle, but by the gliding of skin-flaps from both sides of the leg, this raw surface had been much reduced in size.

Resection of Shoulder.

A young man, whose right shoulder had been resected in October of last year for extensive tuberculosis involving mainly the head and the surgical neck of the humerus, was presented with the object of showing the free range of movement and the functional capacity of the whole limb that may be attained after this operation.

Syphilitic Eruptions.

The characteristic distinctions of early and late syphilitic lesions of the skin were shown by the comparison of a well-marked and extensive papular syphilide, with an ulcerative cutaneous affection well represented in a syphilitic patient under the care of Mr. Wm. Turner.

DISEASES OF THE NOSE AND THROAT.

BY STCLAIR THOMSON, M.D., F.R.C.S.

Friday, July 18, 1902.

Syphilis of the Pharynx and Nose.

A MAN of 30 years, with a breaking down gumma on the posterior wall of the pharynx and loss of the uvula from ulceration, was shown as an example of the effects liable to be produced by syphilis in the region of the fauces and pharynx. The state of the uvula was explained as the result of the formation of a gumma, and it was pointed out that, as such a condition usually commences on the posterior aspect of the uvula, it is apt to be overlooked unless a posterior rhinoscopic examination is made. Hence the practitioner may not suspect the real state of affairs until there is perforation of the soft palate and the mischief is done. Frequently

the development of gumma of the uvula is associated with a similar condition of the posterior pharyngeal wall, and this latter is therefore a suspicious fact. Early diagnosis is an urgent demand, as the cicatrization which follows extensive ulceration is apt to produce adhesion of the soft palate to the wall of the pharynx, and to cause considerable distortion and contraction of the neighbouring parts—a condition very difficult to treat with success. Still it is noteworthy that many patients who have considerable dysphagia during the active stage of the ulcerative process manage to swallow and breathe without difficulty, even though the communication between the naso-pharynx and the buccal-pharynx is reduced to a mere chink. The tendency to deformity from cicatrization is one of the most troublesome features of syphilis affecting the upper air passages. One of its results is seen in the collapse of the bridge of the nose. This is not due to destruction of the nasal septum. It may, of course, be caused by disease of the nasal bones or of the nasal processes of the superior maxillary bones, but in most cases it arises from cicatricial tissue formed in the healing of syphilitic lesions within the nasal cavity. These facts emphasise the importance of early diagnosis and prompt treatment, for in this way alone can the above results be prevented. On the question of treatment Dr. StClair Thomson insisted on the importance of mercurial inunction. He suggested that at the outset mercury perchloride with potassium iodide should be given by the mouth, advising the mixture to be taken well diluted and on an empty stomach. But he urged that a complete cure could only be obtained by the subsequent practice of systematic inunction. Before this is commenced the patient's teeth should be put in good order, and the use of alcohol and tobacco should be prohibited. At first, say for a week, freshly prepared mercurial ointment in ʒss. doses should be rubbed in every night. Then the dose should be increased to ʒj., and this should be continued from four to six weeks. It is a good sign if during treatment the patient gains in weight. Fortunately this is the common experience. Loss of weight means depreciation of the general health and is a cause for anxiety. After the first course of mercurial inunction the treatment may be suspended for six months, provided that during that time there are no evidences of active syphilis. Then a second course of inunction extending over four-

teen days is ordered, and this is repeated on two subsequent occasions with an interval of six months between them. After this the patient may be regarded as cured. At least it is certain that few show any further sign of the disease, and in particular, even though the earlier affection of the throat has been severe, there are none of the sclerosing and cicatrizing processes which lend to untreated syphilis in this region such unfortunate features.

A Case of Nasal Polypus.

A woman of 36 years was examined and found to be the subject of nasal polypus. Dr. StClair Thomson remarked on the patient's age in reference to the existence of polypi, and said that when these are present in middle-life it is well to speak somewhat cautiously in reference to prognosis. It is always possible that behind the polypi there may be some more serious condition, possibly of a malignant nature. And it may be that the latter may only assume an active phase some time after the polypi have been removed. It is therefore advisable to have polypi removed in such circumstances examined by an independent pathologist. This will secure the protection of the surgeon in the event of future developments. Attention was also drawn to the advantage of using adrenalin in association with cocaine. The adrenalin appears to prevent the absorption of cocaine and thus obviates the risk of syncope and other results of cocaine poisoning. Adrenalin, too, it may be remembered, is a cardiac stimulant and therefore has direct advantages as opposing the chance of shock.

A Case of Paroxysmal Sneezing

A young woman, sent by Dr. Drummond Morier, complained that she had for some years been troubled with attacks of sneezing attended by a free watery discharge from one nostril. Examination of the nostrils detected nothing more than a moderate deflection of the septum nasi. In these cases it is necessary to remember that three separate influences may be concerned. First, there is the idiosyncrasy of the patient in reference to particular kinds of dust, etc.; secondly, there may be within the nasal cavity one or more specially irritable points; and thirdly, there is the patient's diathesis.

It follows from this that local treatment of the nose, for example, the removal of a nasal spur, is no sure guarantee that the sneezing will cease. Often it does so for a time, but recurs at a later date. In the present case, Dr. StClair Thomson advised general care of the patient's health and the administration of tonics; it might also be well to give, about the time the sneezing attacks come on, small doses of atropine and strychnine. Regarding the deflection of the septum he doubted the advisability of performing an operation. In bad cases, operation for this condition can be performed, and that with great benefit, but in this patient the air-way was by no means completely blocked. On the convex side of the deflected septum the mucous membrane had a spongy and congested appearance, and it was suggested that this might be touched with chromic acid fused on the end of a probe.

A Case of Fluid Effusion into the Tympanum.

A middle-aged man complained of deafness and a sense of "something in his ear," both symptoms being of sudden origin. After examining the ear, Dr. StClair Thomson expressed the opinion that there was free fluid present in the tympanum. He said such cases were more common than is generally supposed. A patient after bathing often complains that "some of the water has got into his ear," whereas the real state of matters is that some disturbance of the circulation has led to effusion within the tympanic cavity. The use of Politzer's bag, by scattering the fluid, may relieve the sensation and promote absorption. Another useful measure is the inhalation of menthol. The formula is menthol one drachm, dissolved in two ounces of rectified spirit; one drachm of this solution to be added to a pint of hot water, and the steam inhaled.

Other cases included (1), a patient, the subject of anosmia, and (2) a woman showing evidences of secondary syphilis of the palate, with a baby of 11 weeks suffering from inherited specific disease.

DISEASES OF THE EAR.

BY RICHARD LAKE, F.R.C.S.

*Friday, June 13, 1902.**Examples of the Radical Mastoid Operation.*

THE cases exhibited were a series of mastoid operations at various stages of healing, with the exception of one patient, who had been sent up for consultation a few days previously by Dr. Christie, of Chiswick. This man had suffered with suppurative otitis media for a few weeks and had developed symptoms pointing to mastoid involvement. The treatment adopted had been hot irrigations with boracic lotion to the external meatus every four hours, together with the application of six leeches over the affected area, and the subsequent use of hot boracic fomentations, which were changed every four hours. This treatment had been carried out for forty-eight hours, and had been completely successful, all indications for operation having subsided.

The next patient was a young man of 18, who had had both antra opened and the radical operation performed. On the right side the whole cavity had been lined with a single skin graft, while the left was being treated without skin grafting, as the patient refused to have another administration of an anæsthetic. The reason that the operations were performed was on account of the failure of ossiculectomy to control the discharge. The operation of ossiculectomy had been performed a few years ago; and when the mastoids were opened the antra were found to be extremely large, and efficient drainage was not to be obtained by ossiculectomy.

The next patient was a girl of 21, who had also had the radical operation performed on both sides, and in whom skin grafting had only been done on one side, the reason for the operation being intractable otorrhœa. Before operation she had exhibited such a low degree of mental vigour that it seemed she would never be able to earn her own livelihood, but since the operation she had marvellously improved, being now quite bright and intelligent. An interesting

point in this case was that the grafted ear had thrown off recently a complete epithelial cast.

Mr. Lake said that he had wondered before this whether this skin grafting would be entirely successful, as the fact of covering the granulating surface of the cavity with a thin layer of epithelium would present an exact analogue to the condition that obtains in a cholesteatomatous-forming cavity, and one was a little apprehensive that occasionally a somewhat similar formation of cholesteatoma might occur.

The next patient was a woman of 28, whose right mastoid had been operated on, and skin grafting had been employed. In this case the angle of the facial nerve had been exposed at the time of operation, and as the wound had been freely swabbed out with pure carbolic acid, the occurrence of a slight want of power in the orbicularis palpebrarum on that side, which lasted for about a week, was hardly to be wondered at. The details of the operation were considered and its indications enumerated and discussed.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. HUTCHINSON.

(Continued from page 354.)

An Exceptional Form of Lupus Erythematosus.

(Dr. Sequeira's Patient.)

In this case the conditions were much like those described at page 309. The patient was a stout girl, aged 13. Two red patches, one on each side of the bridge of the nose, suggested that she had been wearing a pince-nez which nipped her. The rest of the nose was free, but on both eyelids, on both sides, were long, oval patches of dusky erythema attended by very slight desquamation. Nowhere was there any thickening, nor any lichen spots or discs. It was a dull plum-tint erythema only. Low down on the left cheek was another erythematous patch, in which the punctate spots were not, as elsewhere, quite confluent. It resembled the patches in Dr.

Day's case.¹ The history was that the conditions had been present four months. They had during that time varied a good deal, but had never wholly disappeared. It was, however, alleged that some patches had formerly been present about the mouth which were not now to be found. Her parents were living, and there was no history suggestive of tuberculosis, excepting that an infant sister had died of "water on the brain."

May the Subjects of Inherited Syphilis Expect Longevity?

I have repeatedly asked attention to the fact that the subjects of inherited syphilis, when they attain adult age, usually settle down into good health, and are not liable to any accessions of specific symptoms. This is not quite invariably true, but it is remarkably so in many instances. When a patient has passed through an attack of keratitis and attained the age of thirty, there is seldom anything else to follow. Now and then a gumma-tumour may develop, but they are exceedingly rare. Several excellent instances in confirmation of this statement have recently come under our observation here. I have also in private seen some remarkable instances. Some of these I will mention. A gentleman whose son I attended for a most severe attack of interstitial keratitis recently consulted me about his own condition, and the opportunity occurred for enquiry about his son. I was told that he was in excellent health, actively engaged in business, and about to be married. In another instance a similar report was made respecting two brothers whom I had seen in their youth. A Miss M., who is now aged 40, has been under my observation, together with a sister similarly affected, for more than twenty years. Her eyes have suffered so severely from keratitis and choroido-retinitis that one is lost and the other exceedingly defective. She is, however, very plucky, and earns her living as a supervisor in a laundry, holding her position by dint of energy, in spite of her defective sight. She is liable to recurring attacks of retinal epilepsy, during which she is almost blind. Her general health is, however, excellent, and her eyes are no worse now than they have been for a long time. Her sister, two years younger than herself, has recovered

¹ See page 285.

from keratitis with undamaged eyes, and enjoys excellent health and sight.

Single Patch of Zosteriform Morphœa in the Temporo-Malar Region.

A very exceptional example of morphœa was presented to us on May 1 in the person of a Japanese gentleman, who was good enough to attend for the purpose of demonstration. He had on his left temple a large kidney-shaped patch (with its hilus next the eye) of leather-like integument. It was somewhat thickened and of a dirty yellow colour. It was stated to have been present, with but little change, for two years or more, and there were no others. It caused no inconvenience. I had no difficulty in diagnosing it as zosteriform morphœa, and I placed by the side of the patient a drawing from the Museum showing a similar patch of the same size and exactly in the same situation. In that case the patient had, however, other patches. The prognosis was that in the course of time (some years) it would disappear. The locating nerves were no doubt the temporo-malar branches from the second division of the fifth.

*Herpetiform Morphœa involving the area of one fifth Nerve—
Hemiatrophy of Face and, in a remarkable degree, of the
Tongue.*

Another most interesting example of the results of herpetiform morphœa came before us about the same date. Its subject was a young girl of 13, in whom the original attack had occurred in early childhood. The resulting hemiatrophy of the face was very marked. The right half of the face looked shrivelled, and not only the skin, but the bones and muscles also, had been arrested in growth. An extreme condition of atrophic wasting of one half of the tongue claimed our attention. When protruded the tongue was pushed over to the affected side. A central raphé was well marked, and the part to the right of it was a mere fringe to the hypertrophied left half. The right half of the lower jaw was much smaller than the left one, and what should have been the middle of the chin was pushed over to the left side.

In commenting on the case, I remarked that I had seen hemiatrophy of the tongue in almost as extreme a condition as in our

patient in connection with injuries to the nerve in the neck, but never in association with morphœa. Probably it might be found oftener if it were looked for. It has been mentioned as present in several cases, especially of those in which the attack occurred very early in life. It is only when it does so that any very notable atrophy results. "Hemiatrophy of the face" is, indeed, to some



Atrophy of one-half of the tongue, the result of herpetiform morphœa, and attended by facial hemiatrophy (see portrait).

extent, a misnomer. What really happens is chiefly arrest of growth, but in cases such as the present we must admit definite atrophic changes. I briefly alluded to the important questions as to nerve distribution which were involved, but deferred their detailed consideration.

NOTES ON FOOD AND DRUGS.

No. 1.—Arsenic in Beer.

THE greatest quantity of arsenic per gallon of beer which was determined in the Pathological Department of Owens College was $1\frac{1}{2}$ grains. The greatest quantity of beer confessed to by any one patient was 20 pints a day, which would give $3\frac{3}{4}$ grains spread over the whole day. It is, however, by no means to be assumed that the worst beer and the heaviest drinker ever met together.

No. 2.—Different Qualities of Salt.

Some important remarks on the value of salt occur in Paris' Pharmacologia. Vol. II., p. 424. Chloride of magnesium when mixed with common salt makes it deliquescent. Paris says that *it is then unsuitable for curing certain kinds of fish*. He says "I have myself witnessed the bad effects of a diet of unsalted fish."

No. 3.—Iodoform given internally.

Charlouis recommends, as the best remedy for the bone pains of "Yaws," iodoform in pills. He gave five pills three times a day, each containing sixty-five milligrammes. Have any of our readers any experience of iodoform given internally?

No. 4.—Delayed Symptoms of Arsenical Poisoning.

It was observed during the Manchester epidemic that the symptoms of poisoning would sometimes not come on until several weeks after the disuse of the poisoned beer. It was also found (Dr. Dixon Mann) that arsenic might still be present in the urine fifty-two days after admission to the Hospital.

No. 5.—Bovril.

It is late in the day to say anything in praise of an article which has made its own reputation in all parts of the world, of which it is

scarcely too much to say that it has become an agent in the advance of Civilisation. It is sufficient for the expert to give his assurance that *Bovril* maintains the quality upon which its character and its high popularity were acquired.

No. 6.—Virol.

In *Virol* we have an article of food of a more medicated character than *Bovril*. It is designed especially for delicate children, and contains red bone marrow, malt extract, eggs, and lime. These are so combined that a fairly palatable result is obtained, and one which children will take gladly as a substitute for cod-liver oil. Such, indeed, appears to be the place of *Virol*, and we can confidently recommend it for family use.

No. 7.—Bynin Amara.

The *Bynin Amara*, of Allen and Hanbury, confesses in its name that it is not for all palates. It is, however, a most excellent tonic, and may well be allowed to supersede certain other more widely known but less efficient compounds. It contains two bitters, quinine and strychnia, and with them some phosphate of iron, the whole dissolved in liquid malt. It is an excellent alternative for those who do not wish to be driven to Dublin stout, or who cannot digest it. The "Bitter *Bynin*" is, as most are aware, only one of several valuable preparations having malt extract as their base which have been devised by this celebrated firm.

No. 8.—Nux Vomica.

We have often felt surprise that no form of table malt liquor has been produced having *Nux Vomica* as its active and an acknowledged ingredient. The risk of poisoning would be infinitely small. It is possible, however, that there might, at first, be some prejudice to the name. Easton's Syrup has presumably owed its popularity to the strychnia which it contains, and there is probably no single advertised compound concerning which patients are more unanimous that they feel better when they take it. A successful physician of the last century used to advise his pupils to put tincture of *nux vomica* into almost all their prescriptions. "Your patient may perhaps not be cured of his special ailment, but you will

always be told that your mixture has improved the general health. Almost everybody is the better for a tonic, and nux vomica is the best of tonics. It agrees with everybody." Were that physician now living, he would be delighted to observe the repute which his favourite drug has gained. From Martindale's list we learn that this tincture is prescribed more frequently than any other drug, standing ahead even of such generally employed adjuvants as the chloric ether and sal volatile. It is far safer for general use than any preparation of strychnia. Whilst five drops is a very efficient tonic, thirty may be taken without serious consequences.

No. 9.—*Dr. Fowler on Arsenic.*

Dr. Fowler, whose name is associated with the well-known *Arsenical Solution*, practised at Stafford and was Physician to the County Infirmary in that town. In 1786 he published a small book entitled "Medical Reports of the Effects of Arsenic in the Cure of Agues, Remitting Fevers, and Periodic Headaches." In the Preface to this he states that he was led to use arsenic in the treatment of ague in consequence of the success of a secret remedy known as Tasteless Ague and Fever Drops, which, it was suggested to him by the apothecary to the hospital, owed its efficacy to the presence of arsenic. Directions are given for preparing the solution by dissolving white arsenic and purified salt of the fixed vegetable alkali in distilled water by the aid of heat, and adding, when cold, some compound spirits of lavender. The solution contained 4 grains of arsenic in each ounce. Hence the present pharmacopœial preparation corresponds substantially to the original formula. In reference to the presence of the spirit of lavender, Dr. Fowler remarks that this "is added merely for the sake of giving a medicinal appearance, lest, from its being colourless and tasteless, those patients who may be entrusted to drop it for themselves should be tempted to use it with too great freedom." He also suggests that, in view of the alarm that might arise from the proposal to administer arsenic, the preparation should be prescribed as the *Mineral Solution*. A table of doses for different ages is included in the book. From 2 to 4 years the average dose is stated to be 2 to 5 drops; from 5 to 7 years, 5 to 7 drops; from 8 to 12 years, 7 to 10 drops; from 13 to 18 years, 10 to 12 drops; and from 18 years upwards 12 drops, these being repeated

two or three times daily. In several of the cases, however, the doses were considerably exceeded. Thus a man of 24 years is reported "cured of a tertian ague of twenty-six weeks' continuance by taking from 15 to 28 drops of the solution three times a day for five days. . . . The medicine operated as a cathartic, accompanied by griping pains. . . . These effects were much relieved by his taking 2 drams of the paregoric elixir, at bed-time, for two nights." The "general operative effects" of large doses of the solution are noted as nausea, vomiting, griping and purging; sometimes, too, there was loss of appetite (this occasionally also after smaller doses) and "certain swellings . . . of the elastic kind . . . most frequently appear on the face, particularly affecting the eyelids . . . and sometimes connected with a tumescence of the stomach and abdomen, and now and then the tumefactions are general, affecting also the limbs." As "few and contingent effects" it is said that "in several instances it has proved evidently diuretic; yet in two or three it has seemed to diminish the natural urinary discharge. In a few cases it has occasioned an uneasiness, and pain at the stomach, or a slight general eruption like the nettle rash; and in a very few instances it has seemed to produce a sweat, a headache, or slight tremors."

No. 10.—Dr. Fowler on Tobacco as a Diuretic.

Another medicine on which Dr. Fowler made a "Report" was tobacco. He recommended this in the form of an infusion for its diuretic action.

CORRESPONDENCE AND ANSWERS.

A BOOKSELLER'S BLUNDER.—We have all heard of the sufferer from podagra who purchased a French treatise on *Goût* in the hope of finding the newest knowledge as to his enemy. His blunder has however been capped by a Reading bookseller, who prints in a catalogue with which he has just favoured us, the following:—

770 MEDICAL.—The Anatomy of the
Kebla, or a Dissection of the Defence
of Eastward Adoration, lately published
by J. Andrews, Vicar of South Newington,
in Oxfordshire, sm. 8vo. *hf. brown*
mor., 3s. 6d.

1729

A MEMBER writes as follows :—"A specimen of urine has been brought to me, which has the peculiarity of becoming of a deep bistre tint when nitric acid is freely added. It remains perfectly bright, but froths a little. The tint is that of diabetic urine boiled with liquor potassæ, but lighter. The urine has a specific gravity 1027, and the patient has probably been recently very near an attack of jaundice. Boiling with liq. pot. does not produce the tint. I found exactly the same change in colour a week later. Does it denote the presence of any biliary ingredient, and what other tests should I use?"

* * *

OLD AUTHORS ON LEPROSY.—The monk Theodoric, Lanfranc, Bernard Gordon, Du Chauliac, Gilbert, and John of Gaddesden, are mentioned by Dr. Copland as having written with much accuracy on leprosy. Those interested in this subject should also see in the *Edinburgh Medical and Surgical Journal* (vol. lvi., 301) Simpson's paper on Mediæval Leprosy.

* * *

THE FAROES.—L. J. Debes, a clergyman, wrote a description of the "Islands and Inhabitants of Feroe, &c.," which was translated into English in 1676 :—"I find the cause of the leprosie to be the air and the dyet; for here is a pretty cold and moist air, which usually causeth the scurvy in those who lead a solitary life, and this hath a great affinity with leprosy. Besides, the meat of all, especially of the poorer sort, is half-rotten flesh or fish; all their nourishment in summer being likewise fresh fish and sweet milk without any salt."

* * *

"THE Japanese live almost entirely on rice, fish and vegetables, with eggs as a luxury. I have seen dozens of Japanese meals prepared for the families of working people and it is invariably the same three bowls, one of rice, one of mixed vegetables and one of fish, fresh or salted and often raw."—(Caine's "Trip Round the World, 1889.")

* * *

THE Egyptians were great fish eaters, but ate chiefly fresh-water fish. These bred very freely in the numerous canals, ponds, &c., of the Nile delta. Some fish were declared sacred because known to be unwholesome, and were thus kept from the market. Eels were amongst these. The quality is believed to have been poor—they were "insipid and muddy." The Egyptians also cured fish largely. The Israelites remembered with regret "the fish which they did eat in Egypt freely" (Numbers xi. 5). For some time Leprosy was known as "The Egyptian Disease."

THE POLYCLINIC

BEING THE

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CANCER STATISTICS OF THE "SCOTTISH WIDOWS' FUND."

IN publishing the statistics of cancer-deaths amongst those insured in the Friends' Provident Institution we were able to compare them only with those of the public at large, and not with those of any similar Institution. We ventured to express a hope that some other Insurance Offices would, before long, supply material for a yet more instructive comparison. This has now been done in the case of the "Scottish Widows' Fund." In an able report by Dr. Claud Muirhead, the Medical Officer of that Society, the cancer mortality receives full investigation. Unfortunately Dr. Muirhead has restricted his work to males only, but respecting them he gives all the information that we could desire. Briefly, we may say that, on comparing the statistics of this Society with those of the Friends, we find our conclusions fully sustained, and that in exemption from increase of deaths from cancer the Society of Friends appears to stand isolated. At the Friends' Provident there has been no increase, but in the Scottish Widows' the increase has been as in the community at large. Not only this, but the age at which death from cancer occurs has been reduced. The increase has been from seven

to ten, contrasting the septennial period 1874 to 1880 with that of 1888 to 1894. Still contrasting the same periods we find that the average age of death from cancer was reduced by two years. This result is the more impressive when it is added that the average age at death from all diseases has risen two years. It is in cancer alone that it has diminished.

Dr. Muirhead's statistics have additional importance because they show that there has been a reduction of the ratio of mortality from "internal" cancer, and that the increase has been chiefly in the "external" forms. This is of interest in two directions, first, because it discredits the suggestion that the supposed increase in cancer is unreal and due to the better diagnosis of internal forms; and, secondly, because it points definitely to smoking as the cause. We have elsewhere given reasons for the belief that cancer of the mouth, which constitutes the greater portion of what is termed external cancer, is really the cancer of smokers. The fact clearly brought out by Dr. Muirhead that it is in the age-period between 45 and 55 that the increased mortality almost solely occurs, is also in favour of that hypothesis. Many men diminish or abandon the habit of smoking when they pass middle life.

During the septennium 1874-80 of those insured in this office, one hundred and twenty died of cancer, or nearly 5 per cent. of the general mortality. The average age was nearly 62. During the septennium 1881-87 one hundred and sixty-five died, or about $5\frac{1}{2}$ per cent. The average age was a little short of 60. During the septennium 1888-94 two hundred and fifty-two died, or nearly 7 per cent., the average age being, as in the last period, just short of 60.

Dr. Muirhead gives us valuable tables showing the proportion which various structures and viscera have taken in the general mortality from cancer. The stomach heads the list of "internal" organs, and the rectum (by very far) that of "external" organs. We may here remark that in speaking of "mouth cancer" as smoker's cancer it may be reasonable to claim the œsophagus and stomach as appertaining to the mouth. If the saliva becomes impregnated with arsenic from smoking, clearly the poison will reach both these parts. Further, if any considerable proportion of cancer mortality be due to the medicinal use of arsenic, it would probably be shown in increase of the disease occurring in the stomach. The same influences may

not improbably take their share in producing cancer of the rectum, otherwise we know but little of the causes which locate cancer in that region. It is a well-established fact that in acute arsenical poisoning ulcers are often found in the large intestine, but we are not aware of any observations on this point in cases of slow poisoning such as results from the medicinal use of arsenic or from arsenicated beer.¹

From the tables just referred to we learn that the liver comes next to the stomach, and the "bowel" next to the liver. The stomach was the site in 21 per cent. of the cases in which the part affected was named, the liver in eighteen, and the bowel in eight, whilst the œsophagus had a percentage short of 3. The percentage assigned to the tongue in the last of the three septennia was only 4·5, whilst in the first of them it was 7. This improvement we may probably credit to modern operative surgery. For the same reason the lip scarcely claims any victims—in the first two septennia none at all, and the last two only 0·39 per cent.

The curious heading "Tissues" occurs in the table of external cancer, and takes the third place. Surely these had better have been assigned to the undiagnosed—unless, indeed, the word is a misprint.

One clear inference may be drawn from these tables, namely, that it is the alimentary canal which is the site of cancer in an overwhelming proportion of the males dying of cancer who insure in the "Scottish Widows' Fund." It is the liver only which offers any competition. The bones, the testis, the skin, the penis, the kidney, pancreas, lung and brain are nowhere. The obvious inference from this is that it is something which passes through the food passages which, by local irritation, sets up the disease.

As regards the liver, it is well known that it is this viscus to which arsenic chiefly finds its way. In the Manchester epidemic congestion of the liver or interstitial hepatitis was the most common lesion found after death.

Our readers must remember that the insurers in the great Scottish office are by no means all Scotsmen. As to whether it is fair to suppose that its members are more prone to indulge in

¹ It would be well worth while to examine the fæces for arsenic in cases in which it has been given for long periods.

tobacco and stimulants than are those of the Friends' Provident, we may mention that during the twenty years included in Dr. Muirhead's report twenty-three deaths from delirium tremens occurred, and a few from gout. These maladies are, we believe, scarcely known amongst those Quakers who insure their lives.

THE INCREASED PREVALENCE OF CANCER.

IN search for the truth as to Cancer we have ventured, not without much of a landsman's misgivings, on the rock-encumbered sea of Death-Statistics. Whether what we have brought home are diamonds in the rough, or only common pebbles, must be decided in the workshop.

It has been shown beyond any reasonable doubt that there has been, during the last half-century, a great and steadily progressive increase in the mortality from cancer. This has occurred in spite of the vast development of surgery, which now saves many who would formerly have fallen victims. This increase has, in the British Isles and in New Zealand, although occurring in both sexes, been proved to be very disproportionately great in men. In Prussia, men and women have advanced in like proportion, and in a somewhat minor one as compared with England. It has been proved that in men it is the digestive tract, beginning with the mouth and ending with the anus, which almost exclusively suffers from cancer. This tract suffers much less in women. It is impossible, then, to avoid a suspicion that men in the United Kingdom, and even more so in New Zealand, have in recent times, with increasing frequency, been taking something into their mouths which is causative of cancer. It seems further probable that men in Germany have been exposed to this influence in minor degree.

By the comparison of the Statistics of two Insurance offices it has been shown that whilst in the Scottish Widows' Fund the same increase in the deaths registered as "cancer" has occurred which has been observed in the community at large, in the Friends' Provident Institution no increase whatever has been observed. The suggested difference between those insured in these two offices

respectively, is that very few of the Quakers take either beer or tobacco-smoke into their mouths.

The very remarkable prevalence of mouth-cancer in New Zealand, and the fact that it is excessive in women as well as men, suggests enquiry in several directions. Do the women smoke?¹ Do the men smoke more than in other countries? Is the New Zealand tobacco especially contaminated with arsenic? Are the New Zealand dentists, more than others, prone to use arsenic, or have they got any specially arsenicated form of rubber?

This fact as to mouth-cancer is the more noteworthy because cancer, on the whole, is not nearly so common in New Zealand as it is in England. The English and Scottish annual death-rate from cancer is now more than 8 per 10,000 living, whereas that of New Zealand is, like that of Ireland, only 6.

It may, we think, be considered as proved that chimney-sweepers' cancer is caused by the local irritation of arsenic. The fact that neither coal-dust nor wood-ashes could cause it has long been recognised. Neither charcoal burners nor coal miners are liable to soot cancer. Its subjects are chimney-sweepers, stokers, gardeners, and others who come in contact with coal-soot. Now coal-soot contains large quantities of arsenic, and the condition of skin which it produces in chimney-sweepers is, in all respects, exactly like that which occurs occasionally in connection with the too long continued medicinal use of arsenic. The chain of evidence appears, therefore, to be complete.

That the habit of smoking is productive of cancer may be taken to be as well established as that exposure to coal-soot can cause it, but we have not, as yet, demonstrated that in this instance it is the presence of arsenic in tobacco that is influential. Arsenic has been proved to be present in tobacco by several analysts, but only in very minute quantities. The suggestion is that it may be only occasionally present in larger ones, and that thus negative examinations may go for very little. There is no suggestion of intentional adulteration with any substance containing arsenic, but rather that modern methods of drying the leaf over coke-fed flues may permit of its introduction at this initial stage. It is established that in the American plantations the use of coke for this purpose has come more or less into vogue.

¹ We have been assured that women in New Zealand do not smoke.

As we have formerly pointed out, the introduction of gas and the consequent supply of gas-works'-coke as an article of commerce have been coincident with increased prevalence of cancerous diseases. It is from this source that almost all beer has come to contain arsenic in variable and usually quite insignificant quantities, but sometimes in such as are distinctly injurious. It is by no means improbable that the same thing has been going on in reference to kiln-dried tobacco. In suggesting this, however, we must most distinctly admit that the presence of arsenic in injurious quantities in tobacco has yet to be proved.

If we may accept as probable the suggestion that the influence of arsenic in the production of cancer is local, we can easily understand how its ingestion, in connection either with drugs, beer, tobacco, or any article of food, may influence the whole intestinal tract. On the mouth itself neither medicine, beer, nor any kind of food can be supposed to be seriously influential. Such articles, being quickly swallowed, would not be likely to irritate. It is quite otherwise, however, as regards the stomach and intestines. More especially the long delay of fæces in the lower bowel might, if arsenic were present, be very likely to excite disease. The dangers of the mouth appertain almost solely to smoking, with the addition, perhaps, of dentists' adaptations; but the risks of the rest of the alimentary tract belong to all possible sources from which arsenic may gain access to its contents, being greatest in those parts in which lodgment is most protracted. These inferences fit well with the facts that women but very rarely suffer from cancer of the mouth, whilst they share, as regards the stomach and lower bowel, on much more nearly equal terms with men.

It will be obvious that in arsenic we have an exciting, rather than a predisposing cause of cancer. It initiates the disease. In this we may suppose that it avails itself of predisposition; probably, indeed, the influence of the latter is very important. In its turn, however, arsenic may probably become a cause of predisposition. Those who, with ourselves, believe firmly in the inherited tendency to cancer must hold that this risk is greatest when a cancerous subject becomes a parent. This, probably, is not very common, for cancer occurs chiefly in periods of life later than those at which parentage is common. Still it does occasionally happen,

especially in men, that a child or children may be born to a cancerous parent; and when that happens the risk of the establishment of a cancer-prone family may be considerable.

The superior proclivity of certain races to cancer, which is probably well established, must be taken as proof of inheritance; for a race is but an agglomeration of families. Of this we have, apparently, an instructive illustration in the case of the North-east of Ireland, where cancer prevails in almost equal extent with that encountered in Scotland, whence a large part of the Ulster population derives its descent.

OUR COMPOSITE COURSE OF LECTURES.

THE Polyclinic commences next week a new department of its work, we might, perhaps, almost say a novel and important experiment in medical education. It is proposed to have a Course of Lectures, which shall include all departments of Medicine and Surgery, and in which each subject shall be treated by some one who has given special attention to it. Thus the course will be somewhat of the nature of an Encyclopædia, with the difference that the communications will be by word of mouth, instead of on pages of print. This difference is, however, an important one. Inasmuch as the course will, if successful, be repeated from year to year, there will be opportunity of annual re-editing on a scale which not even the most successful encyclopædia can offer. The lectures may also be rearranged from time to time, and gaps supplied, or they may be entrusted to different men. Above all, lectures have the advantage of permitting the introduction of diagrams, or other forms of pictorial illustration, much more liberally than a book-publisher can afford. There is also what to many persons counts for much, the charm of the human voice, and the example of sympathetic interest in the topic.

The Polyclinic possesses in its Clinical Museum great advantages as regards the illustration of such lectures as those now proposed. It can supply plates, portraits, diagrams, &c., bearing upon almost all diseases, even the least common. Of its stores

in this kind the fullest use will be made. The museum will illustrate the lectures, and the lectures explain the museum.

It is intended that these lectures shall be distinctly didactic rather than clinical. For clinical instruction other arrangements have already been made. The best clinical teachers usually keep fairly close to their cases, and do not diverge into general discussions or attempt to review the whole of the pathological relationships of the malady under consideration. For obvious reasons clinical teaching—although, for reasons equally obvious, of paramount importance—must always be fragmentary. Many considerations it would be inappropriate to discuss within hearing of the patient, and many others must be left aside afterwards owing to want of time. It is the duty of the systematic lecturer to supply these deficiencies, and to exhibit in their due relations to each other the different departments of wide subjects. Such is the object of the “composite course” which will be commenced next week.

It will be seen that to such a course there is no natural ending. Nor is it desirable that there should be. Our audience at the Polyclinic is one which is constantly changing, and for whom it is no disadvantage whatever that the same lecture may have been given a year ago. Often, as already hinted, the lecture, although on the same subject, will not be precisely the same, and, possibly, not by the same lecturer. As regards the lecturers the Council will extend its invitations widely, its only guide in selection being recognised ability in reference to the subject to be discussed. Modern facilities for travelling make it possible for dwellers in all parts of the United Kingdom to respond to such invitations, and it is hoped the arrangements now in progress may have their share with other influences now at work tending to weld into one the provincial and metropolitan professions.

As yet, arrangements have been completed only for the first series of the course; that is, from the present date to Christmas. Many promises of assistance during next year have, however, already been received. An advertisement on a former page gives details as to the first series. It will be seen that Sir William Broadbent, Dr. Patrick Manson, Dr. Theodore Williams, Dr. Colcott Fox, Mr. Mayo Robson, Dr. Lewers, Mr. Hutchinson, Mr. Cantlie, Dr. Seymour Taylor, Dr. James Taylor, Dr. Judson Bury, and Mr. Berry are amongst those who will take part in it.

PROPOSED ARMY MEDICAL SCHOOL IN LONDON.

WITH the exception of those who have been immediately concerned in the scheme, we doubt if there are a dozen members of our profession who have given attention to the subject, and who think well of the proposal to establish an Army Medical School with a Hospital of its own in London. The expense will be exceedingly heavy; but far more important than any question of cost, it is to be feared that the outcome will be injurious to the interests of those whom it is designed to serve. It will narrow the scope of the education of those who are to join the public services. There is no need for a special institution for their training, and they would be far more profitably employed in pursuing their studies in the hospitals and schools which already exist than if restricted to one which must necessarily be narrow in its sphere both of practice and teaching. Let the Army Medical Board organise its examinations on the best possible rules, and make them conducive in all respects to sound education; but this done, let it leave its candidates to seek their knowledge where they can best get it. It is not for the interest of the Services that their medical officers should have as their teachers solely, or even chiefly, those who have been engaged in them. If certain special lectureships are desirable let them be provided. That can be done without much cost and without injurious restriction. We applaud the motives of those who have originated the present proposal, but we believe that they are mistaken in expecting good results from it, and we earnestly deprecate any attempt to specialise professional training for the public services.

SYPHILIS IN MADAGASCAR.

SYPHILIS is reported to be very common in Madagascar. Nothing is known for certain as to the time of its introduction, but it was probably not known prior to European intercourse. The habits of

the native population of both races have, however, conduced in every way to its spread. It is a venereal disease to a large extent, but cases of accidental contagion amongst children and others are very common. Fifty years ago it was believed by the natives to be causing sterility in their women and seriously preventing increase of population, but better knowledge, both as regards prevention and treatment, is, it is hoped, already having some influence in its mitigation.

Dr. Wilson, who has practised for some years in Madagascar as medical missionary, informs us that he has never known the diagnosis of "Yaws" given, but it is probable that many of the cases would have been so named if they had occurred in the West Indies. Dr. Davison, who in 1862 wrote some valuable medical notes based on residence at Antananarivo, described a disease known under the name of "Tety," which he said was very contagious, and was attended by condylomata at the orifices and in the armpits. He thought that it was probably syphilis, but he had rarely found a chancre, and it usually spread without any proof of contagion from sexual intercourse. He said that it was so common that it was exceptional to find anyone who had not had it. It was transmissible from parent to offspring, and infants who inherited it had painful bones and condylomata.

CANCER OF THE STOMACH IN THE UNITED STATES.

OSLER found 39 cases of cancer of the stomach among the first 1,000 autopsies in the *post-mortem* room of the Johns Hopkins Hospital.

Welch, quoted by Osler, from the analysis of 30,000 cases of cancer, found the stomach involved in 21.4 per cent. He found the ratio of men to women as 5 to 4. An analysis by Dr. McCrae, of 150 cases of cancer of the stomach, treated in Osler's wards, gave the proportion as 5 to 1.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

THE DISUSE OF SPLINTS IN COLLES' FRACTURE.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

GENTLEMEN,—Some weeks ago we had before us a case of recent fracture of the radius just above the wrist, in which I strongly advocated the treatment of this form of injury, as a rule, without any splint whatever. You saw the patient three weeks later, and I think all were well pleased with the result. My contention was that in what is known as “Colles’ fracture” the carpal fragment is always very short, and that it cannot, as a rule, be in any way influenced by attempts at extension. I urged also that in cases in which there was not firm impaction, yet still the broad surfaces of the broken bones sufficed to lock them together in such a manner that no subsequent movement was possible. I insisted also that the attempt to press fragments of broken bone into place by pads or other adaptations of the splint was very bad practice, and certain to result in stiffening from adhesions. My conclusions on these points were arrived at long before we had the advantage of the X-rays, and were the result in part of observations on the living and in part of dissections. We have now, in radiographic delineations, a most valuable aid to precision with reference to the position taken by bones when broken. These are especially valuable with regard to Colles’ fracture. At the recent meeting of the British Medical Association at Manchester the annual Museum contained a large and most instructive series of these radiographs, contributed chiefly by Mr. Robert Jones, of Liverpool, for whom they had been executed by Dr. David Morgan. Probably no better radiographs have ever been produced, and I have great pleasure to-day in showing you



A recent Colles' Fracture (2 days). (Radiograph lent by Mr. Robert Jones and Dr. David Morgan, of Liverpool.)

some of them. Mr. Jones and Dr. Morgan have kindly placed their series at the disposal of the New Sydenham Society, and a considerable selection of them will appear in the Clinical Atlas which that Society is now issuing. I studied with great interest all the photographs which had reference to Colles' fracture, and with the result that I did not see a single one which suggested that any advantage could have resulted from the use of splints. In some cases, indeed, in a large majority, the displacement of the carpal fragment is insignificant, and not the slightest advantage could possibly accrue from attempts to rectify it. In some the bone is simply cracked across without any displacement whatever. In the minority, in which there is definite displacement, it is yet by no means very considerable, and all that I have just said as to the impossibility of rectification thoroughly applies. I speak from the examination of many other radiographs in addition to the valuable series I have referred to.

I show you another radiograph (one of several lent me by a friend), which illustrates very well the only partial success which the old methods of treatment attained. Before showing it, however, I will read you verbatim the notes which I find on the back of the picture. I never saw the patient, nor, I believe, did my friend, and it is not in our power to add any additional facts. You will see that it was carefully diagnosed and treated *secundum artem*. We cannot doubt that every effort was used to get the parts into good position at the time of the application of the plaster case. The following are the notes as taken at the date of the radiograph :—

"Wrist broken October 14. In plaster five weeks and two days, till November 20.

"Massage ordered November 20 daily. In sling for a week, then taken out, and ordered for the first time to use it slightly.

"December 23. Massage stopped, as arm had become crooked.

"December 27. Chloroform given and muscles relaxed; plaster two days; wooden splints three weeks, and patient ordered to try and move it as much as possible."

Thus we see that after thirteen weeks treatment, almost complete rest the whole time, and the use of chloroform in the tenth week, the condition of things was far from satisfactory. Our own patient without splints was using her arm at the end of a month, and although there was, of course, some displacement, there was no

stiffening. If we now look at the radiograph we shall see that there was rather deep impaction, and that accurate reposition of the bones had never been effected. The record on December 23 that the "arm had become crooked" did not mean that the bones had suffered any fresh displacement—such would have been impossible—but simply that as the swelling subsided the original deformation was becoming revealed.



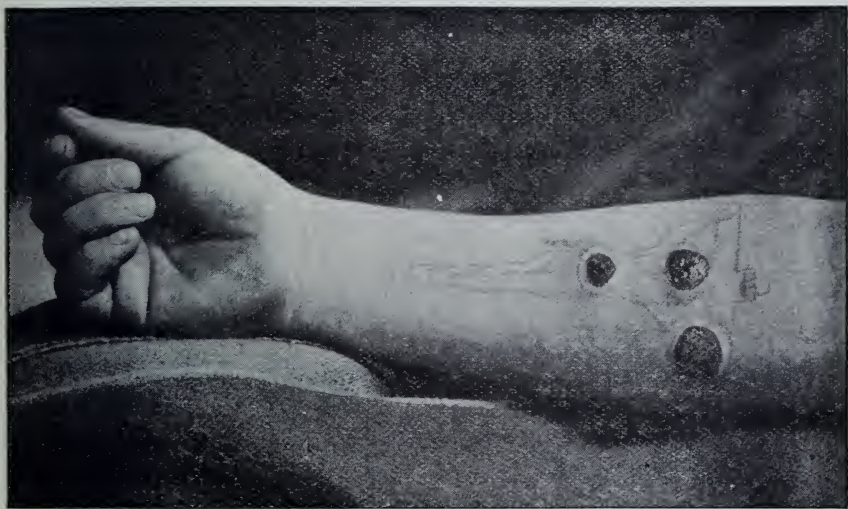
Radiograph of the wrist thirteen weeks after a Colles' fracture, treated by a plaster case. Impaction of lower end of shaft in carpal fragments.

You will understand, gentleman, that in what I have said, I am speaking only of the injuries which are known as Colles' fracture, that is, of those in which the lines of fracture cross the thick, expanded carpal end of the radius. If the fracture is higher up, at a part where the bone has narrowed, the use of splints may be advisable.

As a practical rule I might almost say that unless the ulna is broken also, the case does not need a splint. So long as the ulna is entire, it serves as a splint, and no great amount either of shortening or of lateral displacement can occur. In any case in which there is displacement which you can easily remove by extension, and which returns when extension is remitted, use splints, but not in any others.

ON FRAMBÆSIFORM CHANCRES.

Gentlemen,—I have repeatedly asked attention to the fact that erratic chancres—that is, chancres on other parts than the genitals—but seldom exhibit characteristic induration. They may vary very



Three primary chancres from tatooing in an Englishman. They were raised and firm. (From photograph given by Mr. Crossley Wright, of Halifax.)

greatly in their features, and amongst the conditions which they not unfrequently assume is that of a mass of granulation tissue having some considerable elevation and not unlike a small raspberry. This I have represented in one of my plates illustrating the kind of chancres resulting from contaminated vaccination, and it was still better shown in a photograph given me by Dr. Crossley Wright, of Halifax, in which the sore was produced by tatooing. I again show you this in order that we may remind ourselves of the appear-



Chancres, the result of tatooing. Third month. (From photograph lent by Mr. Thelwall Thomas.)

ances produced and also have an opportunity of comparing it with some fresh photographs bearing upon the same. In the Annual Museum of the British Medical Association in August last, Mr. Thelwall Thomas, of Liverpool, exhibited a photograph so like that



*Chancre, the result of tatooing. (From photograph lent by Mr. Thelwall Thomas.)
Dr. O'Hagan's patient.*

given me by Dr. Wright that I thought at first sight it must have been taken from the same patient. I observed, however, that there were two sores instead of three. I corresponded with Mr. Thomas, and he very kindly sent me a third photograph exhibiting quite similar conditions, but with only a single sore.

In all three cases the chancres resulted from tatooing, and in all the diagnosis was confirmed by the subsequent occurrence of constitutional symptoms. You see how almost exactly alike were the chancres in each instance, and also in each sore when there were more than one. In all it was an elevated mass of florid, rather firm granulation tissue, placed on almost healthy skin and exhibiting no approach to the disc of cartilaginous induration which we recognise as the Hunterian chancre. It is of importance to demonstrate this fact, and to establish it by the concurring testimony of these three witnesses, because it may save some diagnostic mistakes in the future. It is also of great interest because it is this framboesiform character in the primary and secondary lesions which has been so much insisted upon as the feature which distinguishes what is called "Yaws" or "Framboesia tropica" from syphilis. We see that beyond a doubt the primary sore of English syphilis may be framboesiform.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY JAMES TAYLOR, M.D., F.R.C.P.

Tuesday, September 9, 1902.

A Case of Hemiplegia.

THE patient, a man of 30 years, in December last, when opening the door of his house, suddenly fell to the ground and became unconscious. He remained in this state for some hours, and on recovering was found to be the subject of left hemiplegia. He has regained to some extent the power of his leg, so that he is now able to walk about, though in a somewhat halting fashion, but the upper limb remains useless and is the seat of some degree of late rigidity. Discussing the pathological diagnosis in cases of hemiplegia generally, Dr. Taylor said that in the majority of cases occurring in patients at and after middle life, the question was one between cerebral hæmorrhage and thrombosis. Hæmorrhage is suggested by the occurrence of unconsciousness, by the onset of this during or shortly after over-exertion, and by the persistence of the coma for some hours or days; cardiac hypertrophy and a high tension pulse are facts tending to confirm the diagnosis. In thrombosis the patients are usually at a more advanced age—over 60 years, rather than between 40 and 55—and the condition often occurs whilst the patient is asleep or resting, the paralysis being only detected when he endeavours to move his limbs; the action of the heart and the pulse usually show evidence of weakness, and there may be a history of over-exertion some hours before the onset of the attack.

The prognosis is much more favourable in thrombosis than in hæmorrhage. In the latter the great majority of the patients die after a longer or shorter period of more or less complete unconsciousness. In patients under 40 years of age the diagnosis usually rests between embolism and specific disease, the latter producing endarteritis and blocking of the affected vessels. The practical rule for purposes of treatment is to regard the case as syphilitic unless there is evidence of cardiac disease, a history of rheumatic fever, or albuminuria. In the present case there were both a history of rheumatic fever and physical evidences of mitral stenosis—the lesion of all others most frequently associated with the incidence of embolism. In reference to the occurrence of unconsciousness it has to be noted that embolism displays a very varying record in this respect. If the embolus is large and a large artery is therefore blocked, loss of consciousness is to be expected. On the other hand, the sudden obstruction of a small artery is not likely to be attended with any such result, and, further, the area of paralysis will be correspondingly restricted. In reference to immediate treatment it must be remembered that in cases of embolism the heart generally needs attention. The embolus does not always, or indeed generally, originate in a deposit on the curtains of the cardiac valves. The valvular disease, leading to dilatation of auricle or ventricle, or of both these cavities, is apt to be accompanied by intra-cardiac thrombosis, and it is from this source that the embolus is often contributed. The prognosis in hemiplegia due to embolism—and the same is true of thrombosis—is relatively favourable. However severe and widespread the paralysis at the outset, it generally happens that at least some measure of improvement takes place. Even in such a severe case as the present, a considerable measure of activity has been regained.

Paraplegia from Pott's Disease.

A lad of 16 years, with a marked family history of tubercle, began to complain in December last of weakness of the lower limbs. He noticed this more particularly on the left side. Thus, when dismounting from his bicycle and putting his left foot first on the ground, he fell on several different occasions. In addition he observed that he did not “feel properly” when clothing or other

objects were in contact with his left lower limb. When he presented himself at the hospital in April last there was decided stiffness of his gait and dragging of his feet, so that, as he put it himself, his "toes caught the ground." In commenting on this record Dr. Taylor said that a gradual paraplegia should always suggest the possibility either of a tumour pressing on or involving the spinal cord, or of disease of the vertebræ. In the present patient no appreciable angular curvature could be detected, but there was distinct stiffness of the lower back, and this, taken in conjunction with the family history, the account of an attack of pleurisy in the patient himself, and the gradual paraplegia, was held to justify the diagnosis of caries of the spine with pressure paraplegia. A feature of much interest was the state of the tendon-jerks. The knee-jerks were obtained with great difficulty. On the other hand, there was distinct ankle-clonus. The conclusions from these facts were (1) that the lesion had injured the spinal centres which command the reflex arc governing the knee-jerk; and (2) that below the level of the lesion the motor tracts had become the site of a descending degeneration (lateral sclerosis) which expressed itself clinically in the presence of ankle-clonus.

The patient had much improved under rest with extension and counter-extension. Later, when allowed to go about with a suitable jacket, he had somewhat over-exerted himself, and this had been followed by the appearance of an abscess in the loin. Respecting operation in cases of paraplegia due to spinal caries Dr. Taylor expressed himself as inclined to a conservative view, especially in the case of children. He had seen patients recover under rest, even though evidences of improvement had been long postponed—twelve months or more. Operation, it must be remembered, does not remove the disease. It is, in such cases, simply a mechanical palliative measure. With an intra-spinal tumour pressing on the cord the position is quite different. Surgical interference in such cases is most satisfactory and ought to be strongly advised.

Cases of Tabes Dorsalis.

The first of these was of considerable interest inasmuch as the patient was only 24 years of age and had been troubled with ataxia

and other symptoms for fully two years. The clinical evidences included Argyll-Robertson pupils, absence of the knee-jerks, considerable ataxia, and disturbance of the functions of the bladder. In a second patient, a man aged 40 years, there was only a slight degree of ataxia, but in addition to loss of the knee-jerks and myosis there were perforating ulcers on the sole of each foot.

BY C. O. HAWTHORNE, M.D., M.R.C.P.

Tuesday, June 24, 1902.

A Case of Extra-Cardiac Pulsation.

The facts in this case are readily appreciated, but their interpretation is somewhat more doubtful. The patient, a man of 22 years, regards himself as quite well, and has only come to hospital because, after a medical examination, he has been refused admission to a Friendly Insurance society. The reason for that refusal is at once evident. In the second intercostal space on the left side there is a fairly conspicuous pulsation. It is without doubt abnormal, and the question to be determined is, what is its clinical significance. In the first place we may feel fairly sure it is not due to an aneurism. The patient's age alone almost forbids such a diagnosis. An aneurism of the ascending aorta often causes pulsation in the upper right intercostal spaces, and when the dilatation is in the transverse part of the arch there may even be visible pulsation to the left of the sternum—but rather in the first than the second space. Further, there are no other physical facts or symptoms which in the least suggest aneurism. Therefore the probability of that diagnosis may be dismissed. The alternative explanations of the pulsation are not numerous. Practically they are limited to the left auricle of the heart and the pulmonary artery. There are two reasons for concluding that in this case the pulsation is produced by the pulmonary artery. First, the active phase of the pulsation, so far as can be judged, coincides with the cardiac impulse (apex beat), and therefore with the systole of the

ventricle. A pulsation due to the contraction of the auricle would necessarily slightly precede the cardiac impulse. Again, when the hand is placed over the second left space the "snap" produced by closure of the pulmonic valve is felt with great distinctness. These facts seem sufficient to justify the conclusion that the pulsation depends immediately on the pulmonary artery. But there still remains the question why, in this patient, the pulse of the pulmonary artery is visible on the chest wall. The suggestion of an aneurismal dilatation of the artery we need hardly consider. If such a thing occurs it must be extremely rare. The most usual explanation of the condition we have here is that the pulmonary artery is uncovered in consequence of retraction of the edge of the upper part of the left lung. And such retraction is generally the result of fibrotic changes due to tubercle. But our patient denies that he has any symptoms of disease in his chest, or indeed in any part of his body. Physical examination, however, leads to a somewhat different conclusion. There is undoubted flattening and deficient respiratory excursion over the upper left chest; and the respiratory murmur here is of a harsh quality, the expiratory sound is prolonged, and there is exaggeration of the vocal resonance. These facts certainly prove some consolidation of the upper left lobe, that is, they establish the existence of changes in that part of the lung of a nature likely to lead to retraction of the lung and to exposure of the pulmonary artery. Thus we have succeeded in finding an explanation of the abnormal pulsation in the second left intercostal space. And in doing so we have discovered that the case belongs clinically, not to the cardio-vascular, but to the pulmonary group. It is an example of disease at the left pulmonic apex. What is that disease? Doubtless the pathological change is of the nature of fibrosis causing consolidation and shrinking of the pulmonary tissue, and the presumption arising from experience is that this depends on tubercle. There is this further to be said, that after much questioning the patient now remembers that some four months ago he expectorated every morning for a fortnight some blood-tinged sputa. He speaks very lightly of this, but admits that it impressed him to such an extent that he attended a hospital for ten days or so. Taken together with the physical facts, this history of blood-spitting cannot be readily dismissed. Though, if

we conclude that the case is one of pulmonary phthisis we have to face the almost entire absence of symptoms, both now and in the past, and must suppose the tubercular process to be of extreme chronicity. It is a familiar experience in cases of pulmonary tubercle to find well-marked signs of consolidation and fibrosis with a relatively slight manifestation of the general symptoms of the disease, but the contrast here is unusually sharp. Possibly we have to do in our present patient with a cicatrized tubercular lesion, the active stage of which produced symptoms now entirely forgotten. The only other possible explanation seems to be that the alveoli of the upper lobe of the left lung have never been fully expanded, and that, as is known to occur in such circumstances, the bronchial tubes have become dilated. Hence, possibly, the dull percussion and the harsh character of the respiratory murmur. But taking all the facts together, a chronic tubercular process is the more probable, and, acting on this suspicion, the patient will be kept under observation, and every attempt will be made to promote his nutrition and general vigour.

Other cases included (1) two patients with nystagmus; (2) a young man, the subject of cleft uvula; and (3) a patient with constricted visual fields, Argyll-Robertson pupils, and absence of the knee-jerks.

Tuesday, September 16, 1902.

Extra-Genital Chancre followed by Secondary Syphilis, including Iritis and Facial Paralysis—Extreme susceptibility to Mercury.

THIS case had several features of interest, and, in particular, it illustrated some important considerations in reference to treatment. The patient, a woman of 30 years, acquired syphilis in June, 1901. She was helping to nurse a neighbour known to be suffering from mucous papules and other evidences of specific disease, and most unfortunately she managed to infect a small scratch over her right eyebrow. When she first came to the hospital she had a sore in this situation, and this was soon followed by an abundant macular and

popular rash all over the body. She was ordered a grain of grey powder four times a day. In a week's time she returned with evidences of salivation. The mercury was therefore stopped for a time and was afterwards ordered in much smaller doses. But again salivation occurred. And to compress the history of several months into a few words, it may be stated that this experience was repeated with various preparations of mercury, both with and without potassium iodide, and including the practice of mercurial inunction. During this time the patient had a very unhappy experience, for she suffered from extensive ulceration of the lips, tongue, and fauces, and various local applications gave little or no relief. At one time mercury was entirely discontinued in order to try the combination of potassium iodide with compound decoction of sarsaparilla, but this in turn proved of no avail. She was then ordered two or three drops of solution of perchloride of mercury, a dose which was cautiously increased to five drops three times a day. This proved most successful. The ulcers in the mouth and throat rapidly and completely healed, and the skin eruption disappeared and has not since returned. The case is thus an example of unusual susceptibility to the action of mercury, and Dr. Hawthorne contrasted it with an instance in which the patient took 30 grains of blue pill daily before any signs of the physiological action of the remedy appeared. He suggested that these were only extreme instances of a general truth, namely, that each patient had an individual relationship to any particular medicine. Hence the question of dosage for the individual patient cannot be settled by the statement of an average by a pharmacopœial or other authority. It falls to the practitioner to judge in each case when a suitable dose has been administered. In the present instance, had adhesion been given to the authoritative dose of the mercurial preparations, the remedy would have had to be given up as impossible for this individual patient, and thus a great therapeutic possibility would have been lost. But by adjusting the dose to the tissue reactions of the patient the very best effects had been obtained. No doubt this is an extreme instance, but the principle it illustrates is universally true, namely, that doses must be selected not as a matter of routine but in accordance with what experience shows to be the requirements of the individual.

Another feature of interest in the case was provided by an

account of the successful treatment of a severe iritis. This had occurred in both eyes and had been at one time a very troublesome feature. Examination of the present condition of the patient's eyes shows the pupils to be quite mobile and the visual acuity to be at the normal standard. It is possible to detect one or two dots of pigment on the anterior capsule of the lens, but, apart from this, there is now no evidence of the severe inflammation that formerly existed. This result was attributed to the persevering use of leeches, and to the application of atropine. On the right side, which was the one first affected, no less than thirty-five leeches were applied—two, three, or four, two or three times a week, sometimes, indeed, daily, according to the degree of pain. When the left eye was attacked a total of twelve leeches was sufficient to control the inflammation. Dr. Hawthorne emphasised the value of free and repeated leeching in cases of iritis, and spoke of the efficacy of the same treatment in other conditions such as an overloaded right ventricle and congested liver in cardiac disease in children, and the early stage of congestion and inflammation of the kidneys following scarlet fever.

The third aspect of the case to which attention was directed was the existence of right facial paralysis (Bell's palsy). This had occurred in April of the present year. It was at first complete, and the muscles soon lost their response to the faradic current and displayed the reaction of degeneration. The use of the continuous current was steadily persevered with, a daily application of 5 to 15 minutes being practised. Now there is so much improvement that the patient can completely close her right eye and has some degree of power over the lower facial muscles. Dr. Hawthorne spoke of the rarity of facial paralysis in the course of secondary syphilis and of the need in such cases for great perseverance with the use of electricity. He submitted the case mainly as a practical example of the conditions which may need attention in order that therapeutic success may be obtained.

Other cases included (1) a woman with extreme graphic urticaria (dermography); (2) a patient with gastropexia and dilatation of the stomach showing peristaltic movements of the stomach wall; (3) a man of 30 years, with right hemiplegia and aortic disease, the latter attributed to an attack of rheumatic fever at 25 years; and (4) a

man, aged 61, the subject of spasmodic blinking of the eyelids and spasm of the adductors of the vocal cords, both symptoms having come on under mental strain, and having much improved under rest, nerve tonics, and free blistering of the front of the throat and the temples; there were no evidences of organic nervous disease.

BY J. EDWARD SQUIRE, M.D., M.R.C.P.

Tuesday, September 23, 1902.

The Curability of Phthisis Pulmonalis.

IN connection with a case of phthisis pulmonalis Dr. Squire made some general remarks on the curability of the disease. He pointed out that it was necessary to distinguish between a cure in the sense of complete removal of the disease and its effects, on the one hand, and simple arrest of the pathological process, on the other. Whatever opinions might be held as to the possibility of securing the former, there was not the slightest doubt that pulmonary phthisis could be arrested, and, as a matter of fact, often is arrested. This is seen in the *post-mortem* discovery of healed lesions (cicatrices) in the apices of the lungs of persons dying from diseases other than tuberculosis. Sometimes, too, physical evidences of such lesions may be detected in patients free from all symptoms of pulmonary disease, and it is noteworthy that in some of these cases it is difficult or impossible to obtain a history of any illness suggestive of phthisis pulmonalis. And again, a patient who is known to have suffered from phthisis pulmonalis may at a later date be found enjoying good general health and free from the physical signs of active disease. In connection with this group of patients, the question emerges whether or not the presence of a healed tubercular lesion in the lung renders its possessor more liable to a fresh infection. Personally, Dr. Squire expressed himself as disposed to the negative view, except in cases where either the destruction of pulmonary tissue had been considerable, or there was extensive fixation of the lung by pleural adhesions. He was inclined to regard

vulnerability as a condition dependent on general rather than local predisposition, and in support of this view he quoted a series of experiments on rabbits which he conducted some years ago.

On the practical aspect of the question it is beyond doubt that any approximation to an effective cure of phthisis pulmonalis is only possible when the disease is of limited extent and in an early stage. This consideration emphasises the importance of early diagnosis. For the purposes of such diagnosis Dr. Squire advised that reliance be placed mainly on thorough physical examination. Tuberculin, and the Röntgen rays, have their value as confirmatory methods, but they are secondary to exact physical diagnosis. The same is true of the bacteriological examination of the sputa. In connection with this it has further to be remembered that the bacilli can hardly be present until some degree of breaking down of the diseased tissue has taken place, and when this has occurred the case is not really in the early stage. There are, moreover, cases of pulmonary tuberculosis which run their course without the expectoration of sputa, and in others, as is well known, the sputa, though abundant, may not contain bacilli. These facts taken together show that an excessive importance may be paid to bacteriological considerations from the point of view of early diagnosis. Neither it nor any other known method gives such reliable results as physical examination of the chest. It is by attention to this that the early and curable stage of phthisis pulmonalis is to be detected. Turning to more advanced cases, it has to be recognised that the chances of obtaining cure, in any sense of the term, are much less than when the disease is promptly recognised. At the best a more or less extensive area of active lung tissue will be replaced by a cicatrix of corresponding extent and carrying with it a penalty of inefficient respiration and breathlessness on exertion. Still, even in relatively advanced disease, a cure giving the patient the capacity to enjoy life or to pursue his occupation does, at times, take place, and it is necessary to take this possibility of quiescence into consideration in offering a prognosis in any individual case.

SURGICAL CASES.

BY REGINALD HARRISON, F.R.C.S.

*Wednesday, September 17, 1902.**Perineal Drainage of the Bladder.*

MR. REGINALD HARRISON, before introducing a case of bladder drainage by the perineal route, took the opportunity of discussing three questions relating to this subject which frequently arise in practice. *First*: What disorders may follow upon a continued state of incompleated urination, or, in other words, imperfect drainage of the bladder by natural efforts? *Second*: In what circumstances may artificial drainage, apart from various forms of catheterism, be advantageously employed, and how may this be best effected? and, *Third*: What are the conditions which call for the regular use of catheter drainage? In discussing the last point, Mr. Harrison thought that if the use of the catheter speedily led to the complete restoration of the function of the bladder, one would not hesitate in recommending its trial with little or no delay in cases of residual urine, but when we recognise that such is not usually the case, and that catheter life when once commenced is seldom ended, the matter was one that required careful consideration. To condemn a man to the use of a catheter for the remainder of his life, however necessary, was no light responsibility. A calculation made by a patient that in ten years he had passed a catheter nearly 15,000 times for himself, furnished material for reflection. Frequency alone was not always a sufficient reason. Incontinence arising from overflow, or decomposition of the urine, rendered the catheter a necessity.

The following are some particulars of the case that was shown and discussed, Mr. Harrison stating that it was selected in order that those present might see a recent instance of an operation for urine drainage in its first stage, together with the apparatus used for this purpose which he had employed for many years, whether drainage was required either for (1) temporary or (2) permanent purposes.

The patient, now aged 58, had been suffering from stricture of the urethra for many years, and this, by neglect, had terminated in abscess with numerous fistulæ. On his admission to hospital the urine was extremely foul and mainly escaped through the false routes. Fourteen days ago an internal urethrotomy was first performed, and a tight stricture divided—then a median boutonnière puncture was made on a full-sized staff, and a gum elastic drainage tube (Harrison's pattern) passed into the bladder. Two days after this a soft rubber control tube was substituted, and on the seventh day the patient was able to get up and go about. He has come up here by himself to-day from the hospital for your examination. The tube fits well without side leakage, and he regulates the emptying of his bladder at will by the tap. His fistulæ, being disused, have closed, and his urine is normal. Later on, the tube will be removed and the opening will speedily heal. It will only then remain for him to pass his bougie from time to time to maintain the normal dimension of his urethra, as all persons who have suffered from stricture should do.

DISEASES OF THE NOSE AND THROAT.

BY W. JOBSON HORNE, M.D., B.C., M.R.C.P.

Friday, September 12, 1902.

DR. JOBSON HORNE presented a number of cases illustrating various pathological conditions of the mouth, tongue, throat, &c., and submitted these for the examination of the members. Afterwards the cases were discussed, and the diagnosis and treatment of each considered in detail. One case of much interest was that of a middle-aged man who complained merely of hoarseness, and who was found to be the subject of paralysis of the left vocal cord. This gave the opportunity for a statement of the various causes of unilateral laryngeal paralyses and for an examination of the patient with a view to detect the presence of any one of these. It was pointed out that as no local intra-laryngeal condition existed competent to interfere mechanically with the movements of the cord, the paralysis must needs be referred to interference with the nerve

supply. Further, as there were no enlarged glands, no goitre or other abnormal condition in the neck, and no evidence of malignant disease in the upper part of the œsophagus, it was necessary to seek for some intra-thoracic condition capable of damaging the left recurrent laryngeal nerve. The physical examination of the chest by Dr. Hawthorne showed defective movement and impaired percussion over the upper left front, with little or no appreciable defect in the volume or quality of the respiratory murmur. The cardiac sounds were normal, but the second sound to the left of the manubrium sterni had a loud ringing character. The bearing of these facts on the diagnosis between aneurism on the one hand and solid mediastinal growth on the other was discussed, and attention was drawn to a relative deficiency of the left radial pulse as a fact favouring the theory of aneurism. The frequency of the association between laryngeal paralyses and intra-thoracic tumours was emphasised.

Another case was that of a man with a condition of ulceration limited to the hard palate, and a third patient was shown with an ulcer of the tongue. The differential diagnosis and the treatment of these cases were considered in detail.

NOTES ON FOOD AND DRUGS.

No. 11.—Quinine and Iron in Gout.

It is an interesting fact in therapeutics that whilst quinine is almost always beneficial to the sufferers from rheumatism and gout, iron is the reverse. Almost all who are liable to recurring attacks of rheumatic gout will allege that they are made worse by steel. A man who was before us not long ago, who inherited gout on both sides and had himself suffered from gonorrhœal rheumatism, is now liable, as a sequel, to recurring arthritic iritis. He tells us that three or four doses of steel will always make his eyes hot and painful.

No. 12.—Treatment of Catarrh.

With the object of cutting short catarrhal attacks of all kinds, the prompt use of stimulants and food is, in combination with external warmth, of the utmost importance. This is in accord with

popular experience which has been enshrined in a well-known proverb. Such inflammations are to a large extent neurotic, and one important factor in the process is a spasmodic narrowing of the peripheral blood-vessels. Now the effect of alcohol and of hot fluids is to counteract that influence, and by restoring the balance of the circulation to prevent local congestions.

No. 13.—The Dosage of Tincture of Nux Vomica.

A correspondent has suggested that the doses of the tincture of nux vomica quoted in our last are too large, and has reminded us that the tincture is now double the strength of what it formerly was. We had not overlooked the latter fact, and the doses were not given at random. Patients have been known to take tablespoonfuls instead of teaspoonfuls of mixtures containing this tincture in full pharmacopœial doses. In using a drug which permits of such latitude the prescriber may feel himself safe.

No. 14.—A Plea for Cheap Quinine.

The cheapening of quinine would be a benefaction to the human race. Medicinally prescribed, no drawbacks appear to attend its use. Not only as a specific against malarial fevers, but as a giver of tone and an aid to the general well-being of the organism, those who would be benefited by its almost habitual use are to be counted by millions.

No. 15.—Starvation in Traumatism.

All traumatic inflammations and all wounds from which traumatic inflammation may possibly ensue should be treated on quite opposite principles to those above hinted at. Here the starvation should be absolute. It is to be desired that the peripheral blood-vessels should be as narrow as possible and everything favouring diapedesis should be avoided. It was said that the late Mr. Lawson Tait owed to his insistence on the most absolute abstinence from both fluids and foods after his operations the very remarkable success which attended them, notwithstanding the neglect of common aseptic precautions. A parallel fact was noted in the recent war. Those who had lain wounded in the battle-field wholly without treatment and tortured with thirst often did better than those who were promptly attended to.

No. 16.—*Dermato-neuritis from Arsenic.*

The following are some facts as to an attack of neuro-dermatitis which followed the use of arsenic in a lady of middle age. She had been asked to write out her symptoms. "I took my first dose of medicine at half-past seven p.m. on the 13th of October, second dose after breakfast on the 14th and the third after luncheon on the same day. About seven o'clock in the evening I first felt an itching on the inside of my right forearm and elbow joint, shortly after great irritation and itching on right side of neck, which soon got very red and swollen. At bed-time it came out on the left side of my body and arm, also very much on both legs and was very irritable all day on the 15th, since which date it has gradually got better, but I do not feel quite free of the itching to-day.—L. W."

CATALOGUE-COMPANION TO THE MUSEUM.

(Continued from page 359.)

The following portraits from Kaposi show precisely the same state of things.

No. 44 K.—T.¹ 204 represents the face of a lad in whom ulcerating lupus has destroyed the greater part of the nose, and drawn down what remains of the lower eyelids. Almost the whole face, including the lips, is covered with crusts and dusky scars. The corneæ are opaque from ulceration of an aggravated type.

AUTHOR'S DESCRIPTION.—"*Lupus vulgaris faciei—consumptio nasi, utraque cornea cicatricibus consumpta.*"

No. 45 K.—T. 205. A very similar portrait to the preceding, but in a girl, and with extension to the neck. Everywhere there are pus crusts.

AUTHOR'S DESCRIPTION.—"*Lupus vulgaris faciei totius et serpiginosus regionis cervicalis.*"

No. 46 K.—T. 219. Two figures on the same plate, evidently from different patients, but with but one description. One of them

¹ The letters K T stand for Kaposi's Atlas Tafel.

shows ulcerating lupus of the nose and lips. The surface of the tongue is affected, presenting deep fissures surrounded by an inflamed area covered with pseudo-papillomatous growths (probably a young person). The other figure shows an ulcerated surface involving almost the whole of the hard palate and under surface of tongue. Evidently from a young person. Excepting that in the second the lips and nose are sound, it might have been supposed that these two illustrated the same case, and the following is the only description given:—“*Lupus vulgaris nasi, labii oris superioris, dorsi lingue, faciei inferioris lingue.*”

No. 47 K.—T. 218. Two figures, probably from the same case, showing a polypoid papilloma hanging from an ulcerated surface on one tonsil, and in the second figure superficial ulceration over the uvula and whole of the soft palate. As in the preceding, no information is given as to whether or not these are from the same patient, but only a single description is given.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris tonsillæ mucosæ, veli palati.*”

No. 48 K.—T. 200. The face of a child with open mouth, showing ulcerating lupus of end of nose, in almost symmetrical patches on the cheeks, and involving also the prolabium of both lips and the soft palate. The hard palate is not seen.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris faciei, labii, oris et palati duri.*”

No. 49 K.—T. 217. The three figures given in this plate are probably not from the same case, but no indication is given that they are not so. One of them shows an extensive serpiginous ulcer with florid edges, involving almost the whole palate. Another shows ulceration and papillomatous growths on the epiglottis and various parts of the larynx.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris lingue, epiglottidis mucosæ, arytenoidæ, palati duri.*”

No. 50 K.—T. 213. The face of a young person, showing lupus vulgaris of the end of nose, on the skin-surface of the right upper eyelid and on the conjunctivæ of both eyes.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris nasi et conjunctivæ oculi, utriusque.*”

No. 51 K.—T. 216. In this plate four figures are given, probably from different patients, illustrating lupus vulgaris affecting the conjunctiva of the eyelids. In one the nose is shown, its tip covered with acne-like spots of lupus.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris conjunctivæ palpebrarum.*”

No. 52 K.—T. 215. This, with the preceding and the following, are valuable illustrations of conditions but rarely seen. In this we have two figures almost identical, and probably from the same case at different stages. The conjunctiva of the eyeball itself is involved, and thick fleshy growths cover part of the edge of the cornea. There is ulceration of the cornea, and possibly perforation. The lower eyelid is notched, as if the disease had begun on it. No part of the face is shown.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris conjunctivæ bulbi—pannus luposus.*”

No. 53 K.—T. 214. The face of a young person with upper eyelid of the right eye everted, showing great vascular thickening of the conjunctiva, and a gray based central ulcer. On the skin-surface of the upper eyelid of the other eye are a group of four lupus-pustules.

AUTHOR'S DESCRIPTION.—“*Lupus vulgaris palpebræ et conjunctivæ palpebræ.*”

No. 54.—In this case the patient, a girl of 15, had suffered from some affection of her palate from the age of 8, and the lesions on the nose had been present from that of 11. On the nose the tubercles were those of lupus vulgaris, and there had been considerable destruction of the alæ. On both lips there were some lupus tubercles. The mucous membrane of the lips, tongue, soft palate, and uvula were all affected, and there was some enlargement of lymphatic glands. The condition of the tongue was of great interest, being mammillated and sclerosed over the greater part of its surface. Experiments by the inoculation of animals proved that the disease was tuberculous; and figs. 6, 7 and 8 show the results of inoculation on guinea-pigs. Figs. 9, 10 and 11 show sections of tubercles of the patient. The rest of the figures illustrate the case and sufficiently explain themselves.—(Plate 3 of the *International Atlas of Skin Diseases*. Prof. Leloir.)

(To be continued.)

CORRESPONDENCE AND ANSWERS.

PRONENESS OF FAT TO BECOME BILE-STAINED.—In cases of jaundice in elderly persons, the arcus senilis usually becomes stained yellow, whilst the rest of the cornea remains clear. This fact, as showing the proneness of tissues containing fat globules to become bile-stained, may be of some interest in reference to the phenomena of xanthelasma palpebrarum.

* * *

DYSPEPTIC.—There are persons who devote their lives to digesting their meals. They become incapacitated for exertion by taking food, and the time needful for rest after one meal extends to that at which another is due.

* * *

OBSTETRICUS.—The deaths from erysipelas in infants is, we believe, usually in ratio with the deaths from puerperal fever in mothers.

* * *

INCUBATION-PERIOD OF MEASLES.—The best observations as to measles were made by Dr. Panum, of Copenhagen, in an epidemic in the Faroe Islands, and proved that the interval between exposure and the first premonitory symptoms is usually fourteen days.

* * *

CONGENITAL SYPHILIS WITHOUT TREATMENT.—A great many syphilitic infants recover without any treatment whatever, the taint having never been recognised.

Such cases may certainly recover without mercury, and I am doubtful whether mercurial treatment does anything to prevent the occurrence of symptoms at a later period.

* * *

"HE LET HIM THROUGH."—The *Wiener Medizinische Zeitung* for the current week, contains an anecdote of the late Professor Virchow which may possibly be new to some of our readers. A student under examination having boggled at what seemed to Virchow very simple questions, the professor at last thrust forward his own arm and asked, "Can you tell me, sir, what is the colour of my coat?" After careful inspection the examinee replied, "It is possible, professor, that it was once blue." In the sequel, it is added that the examiner "liess den candidaten durch."

* * *

OUR contemporary *Punch* gives us this week the following bit of sound advice: "How to get stout. Buy it."

* * *

USE OF PHOSPHORUS BEFORE LUCIFERS.—"Observing Cordelia ready to faint, (for she had lighted her taper with phosphorus, which she carried in her pocket) he reached some water, and begged, on his knees, that she would dismiss all her fears."

The above quotation is taken from "Westing," a novel published in 1801, and is probably a remarkable instance of the proneness of fiction-writers to avail themselves of fragmentary knowledge of Science. Is any information obtainable as to the practice at this period of using phosphorus for the purpose of procuring light, and as to any contrivance by which it might have been more or less safe for Cordelia to carry it about in her pocket?

MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

SCHEDULE OF CLINQUES AND LECTURES

From **SEPTEMBER** to **DECEMBER, 1902.**

Cliniques at 4 p.m.

MONDAYS. (<i>Skin</i>)	TUESDAYS. (<i>Medical</i>)	WEDNESDAYS. (<i>Surgical</i>)	THURSDAYS. (<i>Surgical</i>)	FRIDAYS. (<i>Eye, Ear, Nose, and Throat</i>)
Sept. 8 College opens	Sept. 9 Dr. James Taylor	Sept. 10 Mr. P. J. Freyer	Sept. 11 Mr. Hutchinson	Sept. 12 Dr. Jobson Horne
Sept. 15 Dr. J. Galloway	Sept. 16 Dr. C. O. Hawthorne	Sept. 17 Mr. Reg. Harrison	Sept. 18 Mr. Hutchinson	Sept. 19 Mr. R. Lake
Sept. 22 Dr. A. Whitfield	Sept. 23 Dr. J. E. Squire	Sept. 24 Mr. Jackson Clarke	Sept. 25 Mr. Hutchinson	Sept. 26 Dr. Herbert Tilley
Sept. 29 Dr. Graham Little	Sept. 30 Dr. Harry Campbell	Oct. 1 Mr. James Berry	Oct. 2 Mr. Hutchinson	Oct. 3 Mr. Ernest Clarke
Oct. 6 Dr. J. F. Payne	Oct. 7 Sir Wm. Broadbent	Oct. 8 Mr. J. Cantlie	Oct. 9 Mr. Hutchinson	Oct. 10 Dr. Dundas Grant
Oct. 13 Dr. J. Galloway	Oct. 14 Dr. Seymour Taylor	Oct. 15 Mr. Reg. Harrison	Oct. 16 Mr. Hutchinson	Oct. 17 Dr. St. Clair Thomson
Oct. 20 Dr. A. Whitfield	Oct. 21 Dr. W. Ewart	Oct. 22 Mr. F. C. Wallis	Oct. 23 Mr. Hutchinson	Oct. 24 Mr. Work Dodd
Oct. 27 Dr. J. M. H. MacLeod	Oct. 28 Dr. Theo. Williams	Oct. 29 Mr. J. Berry	Oct. 30 Mr. Hutchinson	Oct. 31 Mr. P. R. W. De Santi
Nov. 3 Dr. J. F. Payne	Nov. 4 Dr. James Taylor	Nov. 5 Mr. J. Hutchinson, Junr.	Nov. 6 Mr. Hutchinson	Nov. 7 Dr. Herbert Tilley
Nov. 10 Dr. Graham Little	Nov. 11 Dr. Guthrie Rankin	Nov. 12 Mr. Jackson Clarke	Nov. 13 Mr. Hutchinson	Nov. 14 Mr. Marcus Gunn
Nov. 17 Dr. Colcott Fox	Nov. 18 Sir Wm. Broadbent	Nov. 19 Mr. J. Hutchinson, Junr.	Nov. 20 Mr. Hutchinson	Nov. 21 Dr. Dundas Grant
Nov. 24 Dr. J. T. Pringle	Nov. 25 Dr. Seymour Taylor	Nov. 26 Mr. A. H. Tubby	Nov. 27 Mr. Hutchinson	Nov. 28 Dr. St. Clair Thomson
Dec. 1 Dr. J. F. Payne	Dec. 2 Dr. W. Ewart	Dec. 3 Mr. E. W. Roughton	Dec. 4 Mr. Hutchinson	Dec. 5 Mr. Treacher Collins
Dec. 8 Dr. J. Galloway	Dec. 9 Dr. Theo. Williams	Dec. 10 Mr. A. H. Tubby	Dec. 11 Mr. Hutchinson	Dec. 12 Mr. R. Lake
Dec. 15 Dr. J. M. H. MacLeod	Dec. 16 Dr. R. L. Bowles	Dec. 17 Mr. J. Cantlie	Dec. 18 Mr. Hutchinson	Dec. 19 College closes.

Clinical Lectures at 5.15 p.m.

Oct. 15th.—Gilbert Barling, Esq., F.R.C.S., Birmingham.
Oct. 29th.—P. H. Pye-Smith, Esq., M.D., F.R.C.P.
Nov. 12th.—Judson S. Bury, Esq., M.D., F.R.C.P., Manchester.

Nov. 19th.—Peter Horrocks, Esq., M.D., F.R.C.P.
Nov. 26th.—Allan Macfadyen, Esq., M.D., B.Sc.
Dec. 10th.—H. E. Juler, Esq., F.R.C.S.

Special Courses of Lectures at 5.15 p.m.

Oct. 3rd, 10th, and 17th.—Mr. Bellamy Gardner, "The Administration of Anæsthetics" (with practical demonstrations).
Oct. 6th, 13th, and 20th.—Dr. G. E. Herman, "Pelvic Inflammations."
Nov. 3rd, 10th, and 17th.—Dr. W. S. Colman, "Infant Feeding, and Ailments due to unsuitable Feeding."

Nov. 7th, 14th, and 21st.—Dr. Louis Sambon, "Parasitism in Man."
Nov. 28th, Dec. 5th, and 12th.—Dr. S. E. Dore, "The Therapeutic Uses of the Röntgen and Finzen Rays" (illustrated by Cases).
Dec. 1st, 8th, and 15th.—Dr. Harry Campbell, "Respiratory Exercises and Thoracic Dynamics."

A. E. HAYWARD PINCH, F.R.C.S., Medical Superintendent.

THE POLYCLINIC

BEING THE
JOURNAL OF THE MEDICAL GRADUATES'
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THE SUPPRESSION OF LEPROSY BY LAW.

A PASSAGE in one of the Annual Reports of the Calcutta Health Society well illustrates the mental attitude in which but too frequently the question of the compulsory isolation of lepers is entertained.

"The Council of the Health Society would observe that it is not necessary to determine whether leprosy is contagious or is only strictly hereditary. It is sufficient to keep in view the loathsome nature of the scourge and the fact that it is incurable, coupled with the circumstances that it was once as widely prevalent in European countries as it is in India at the present time, and that to-day it has been practically stamped out in Europe. . . . The Council have no hesitation in saying that in any other civilised country in the world it would only be necessary to call attention to the facts now stated to insure the immediate initiation of remedial legislation."

A parallel to this line of argument was afforded by the municipal magistrate who informed his court that suicide was, in his opinion, a dreadful crime, that he found it to be on the increase, and that he was determined to use the full force of the law to put it down. Leprosy is a "dreadful malady"; it is "incurable"; therefore, without any regard to its cause, let us have "remedial legislation" to stamp it out. Now as a matter of fact, leprosy never was

“stamped out” of Europe. It died out in all the central regions under the influence of social changes, but it still remains in a broken girdle on the sea-board surrounding the Continent, north, south and west. It is still abundant in Iceland and Norway, and this in spite of the fact that leper homes, precisely of similar character to those in the rest of Europe, have existed in the latter, if not in both, for ages. It does not affect the eastern boundary of Europe, for reasons which are obvious: It may be asserted with confidence that there has never been in the history of leprosy throughout the world any instance of success of the stamping out policy. That policy has failed utterly where it has been most energetically attempted, as, for instance, in the Sandwich Islands, quite recently. It is of course quite possible to improve the statistical records of its prevalence by the radical methods of destroying or driving out of the country all lepers. Such is the kind of success reputed to be gained in Nepaul and in Pondoland, but it is an illusory advantage, for the social habits of the community remaining unchanged, the supply of *de novo* lepers is perennial.

It becomes necessary to speak in quite plain language as to the nature of the success which is at present claimed for the leper laws in Norway. It is possible that this easily accredited success, so loudly proclaimed and so frequently repeated by the contagionist school, is doing very much to hinder the correct appreciation of the cause of leprosy and to favour the enactment of cruel and useless laws. The facts are simple. A century ago the peasantry of Norway were two centuries behind the rest of Europe in all that concerned the comforts of social life—it might almost be said in civilisation. They were poor, and almost the only article of food which was really plentiful was fish. They preferred to eat their fish when a little tainted. Leprosy abounded. They had from the year 1277 had a leper home in Bergen. In the first half of the last century medical opinion in Norway held that the disease was not contagious but hereditary, and new asylums were provided by the State in the hope of preventing the marriage of lepers. They were quite voluntary. In the middle of the century it was believed that the number of lepers had diminished by one half, and from that time to the present the reduction of numbers has been steady and

most satisfactory. No law for compulsory isolation was passed until 1885; and the Act then passed and now in force, allows of local option as to its employment, and, as a matter of fact, one-third of the lepers now in Norway are living with their relatives at their own homes.

During the century a most beneficial change has been silently taking place in the condition of the Norwegian peasant. Great numbers have emigrated to America, and there the race, without exception, has ceased to be liable to leprosy. Those who remained at home have had the comforts and necessities of life vastly increased by the money which has flowed in upon them from the tourists who now annually visit their homesteads. Of these tourists not one who has not remonstrated when offered fish in a state of decomposition. It is even possible that some rumour may have reached the peasants themselves that badly cured fish is accused as a cause of leprosy, and very improbable that this accusation, although verbally rejected by the Norwegian medical profession, has not had some influence on the advice which they give as to food. Now under such circumstances is it reasonable to claim the progressive diminution of leprosy in Norway as the result of the Act of 1885? It began long before that Act was passed and the Act is besides an absolutely inadequate one for the suppression of any contagious disease. Leprosy has, moreover, let it be here noted, subsided during the same period just as definitely in Madeira and many other places where there is no legislation whatever. In the face of such facts, are our Norwegian *confrères* when they vaunt the success of their so-called isolation methods, in any better position than that of the fly on the coach wheel, which flapped its wings and thought that all the dust was its own making?

J. H.

THE INDIAN LEPROSY COMMISSION.

TWELVE years have passed by since a Medical Commission, under the auspices of "the Prince of Wales Committee," sailed from Southampton to investigate leprosy in India. We had almost written have *silently* passed by, for indeed very little has since resulted from the able Report which the Commission presented two years later. That Report, although the result of most meritorious labour, was to a large extent negative. It was received—perhaps on account of its cautious impartiality—with but little satisfaction by any one. It discouraged legislation for segregation by producing evidence that the disease was neither hereditary, nor, excepting perhaps in an infinitesimal degree, contagious. Whilst it approached very closely to an expression of belief that the disease was due to food, it yet threw overboard (after careful examination) the fish hypothesis, since it found that a very considerable proportion of Indian lepers alleged that they had never eaten fish. It contained elaborate data, with maps, &c., in disproof of the suggestion that a defective supply of salt was a cause of leprosy. Thus then our knowledge of leprosy in India was left much where it had been before, and the only practical recommendations which the Commission was able to make were the humane and common-sense ones that places of voluntary refuge for indigent lepers should be provided by the State, that these should be near the homes of the sufferers, and that crowding into large towns should be discouraged. In saying only this the Commission in no wise failed of its duty, for it said all that the facts before it justified. The fish hypothesis it had rejected, and it had found it impossible to pitch upon any other article of food against which any reasonable suspicion could be alleged. Thus there was nothing which it could suggest as to dietetic reform.

It was, however, a definite gain to our knowledge of leprosy in India, that experienced investigators such as those who comprised the Commission could enunciate such conclusions as the following¹ :—

¹ We do not here quote the conclusions of the Committee in their entirety. They will be found at page 416 of the Report.

“That leprosy is not diffused by hereditary transmission.”

“That although in scientific classification leprosy must be regarded as contagious and also inoculable, yet the extent to which it is propagated by these means is exceedingly small.”

“That leprosy in the great majority of cases originates *de novo*, that is, from a sequence or concurrence of causes and conditions which are related to each other in ways at present imperfectly known.”

By the expression *de novo*, is here meant simply independently of either transmission from parents or of personal contagion, and it must be remembered that the members of the Commission were one and all zealous bacteriologists, and entertained no doubt whatever as to the rôle taken by Hansen's bacillus. They did not mean by *de novo* that this bacillus was susceptible of spontaneous generation, or that its presence was not essential to leprosy, but only that it might gain access to the body in some way not as yet understood, but most certainly without either personal contact or inheritance.

It is clear that, in stating their conviction that most certainly the great majority of Indian lepers had not acquired their disease either by inheritance or contagion, the Commission came very near indeed to an avowal of a belief in its food origin. When we further take into consideration their statements that it is not due to climatic or telluric conditions, nor to insanitary surroundings, and that it is not restricted to any race or caste, we have nothing left to think of excepting food. There are indeed expressions in the Report which may be taken to imply much misgiving in the conclusion that “leprosy is not directly originated by the use of any particular article of food.” It is difficult to avoid the impression that had the enquiries been a little more detailed, and had the Commission entertained a little more hesitation in accepting the statements made to them by interested parties, they might have arrived at a much more definite verdict. The Commission rejected the hypothesis that fish is the article of food which causes leprosy in India, on two grounds. They found in the first place that it often prevailed to a greater extent inland than on the seashore or river bank, and secondly, that a very considerable number of lepers said that they had never eaten fish. It does not appear that they made any special enquiry as to *salted* or *dried* fish, and those of whom the enquiry was made would naturally think of fish in its fresh state. Indeed, in some of the forms in which cured fish is

presented in the East, it is hardly recognisable as fish. Of such articles the Brahmin might eat without supposing that he was any accomplice in the taking of life. Now it is this cured fish, and not that freshly caught, which is suspected as the cause of leprosy, and the results are to be expected where it is eaten, and not where it has been cured. In nine cases out of ten the very object of curing is to allow of its being sent inland for sale. It would appear, although it is not distinctly stated, that it was almost exclusively the Brahmins who tendered the statement that they had not eaten fish. This caste is by its religion forbidden to take life, and the Commission appears to have considered the prohibition and the denial as corroborative, whereas less indulgent judges of human nature might have held that the one was a natural sequence of the other. Thus, then, fully admitting that the Commission made a proper use of the statements submitted to them, it must be held that as regards the use of *cured fish* as food their supposed facts were far from bearing out their negative conclusions. J. H.

SEGREGATION IN MINICOY.

THE methods which are now being tried in Norway for the suppression of leprosy by the compulsory isolation of lepers are no novelty. They have been resorted to in the past over and over again, and often with much greater efficiency than is now the case in Norway, and unless they have chanced to be coincident with other social changes, they have always failed. Perhaps one of the most definite examples of such failure is afforded by the little Indian Island of Minicoy. The island is one of the Laccadives, off the west coast of Southern India. It is of coral formation, covered with palm trees, and has a robust, well-fed population of little more than three thousand. They are of mixed descent, but all profess the Mahomedan creed. Excluding, perhaps, the Sandwich Islands and New Caledonia—and, possibly, not even excepting these—there is probably no spot on the face of the globe where leprosy is more rife. On the mainland of India, where segregation has never

been attempted, there is no district where the lepers number more than thirty in 10,000, and in most they are not more than three. In Minicoy it would appear that the ratio is not less than one hundred and fifty.

Yet the Mahomedan creed teaches that a leper is unclean, and should live apart, and the Khazi of Minicoy has for some centuries possessed authority in this matter, at least equal to that which since 1885 Dr. Hansen has had in Norway. In Norway it rests with the parish where the leper is found, at its own discretion, to send the leper to the hospital or let him remain at home. In Minicoy the Khazi's will is law.

An excellent report as to the past history and present prevalence of leprosy in Minicoy from the pen of Surgeon-Major Beech, was published at the Calcutta Government Office in 1896, amongst "*Papers relating to the treatment of Leprosy in India.*"¹ Dr. Beech tells us that the condition of the island, as regards hygienic precautions, is exceedingly bad. "There are no latrines, and fish refuse is strewed about in all directions." The islanders are, however, of fine physique, and "their food is liberal." "They eat three times a day. The morning meal consists of rice, kanji, and, perhaps, Mas fish (Bonito), or hoppers prepared from rice flour and cocoa-nut; the mid-day meal consists of rice and Mas fish, with cocoa-nuts and vegetables, and the evening meal the same" . . . "meat, either mutton or fowl, and vegetables are rarely seen except by the rich." "Mas fishing and the preparation of the Mas is the great industry of the island. The male population catch the fish, and the women prepare it." . . . "This fish is peculiar to this island and the neighbouring one of Kavarathi, and is eaten largely by all classes alike; the poorer classes, perhaps, never having any other kind of flesh or fish. This fish and rice form the staple articles of diet." The quotations we have given are from the preface to Dr. Beech's report. The latter gives us the following detail as to the mode in which the fish is cured.

"From the above it will be seen that the Mas fish (Bonito), either fresh or salted, enters very largely into the diet of the islanders. This fish is used in different ways, such as salted Mas, dried Mas, and a preparation called Rehahakaroo. The dried Mas is prepared by half boiling the flesh of the fresh fish

¹ See page 270, *et seq.*

in sea water, then exposing to smoke, and afterwards drying it in the sun. This preparation is much liked and is eaten generally *without further cooking*, but when prepared as a curry it undergoes further boiling, but retains its former firmness. Salted Mas is either fried or cooked as curry. The Rehahakaroo is prepared by removing the flesh from the Mas fish ; this, together with the flesh which remains attached to the bones, is all boiled in sea water ; after a time the large pieces of flesh are removed from the pot, smoked, dried in the sun, and the remaining liquid is still further concentrated by boiling until it is of a certain consistency, when it is strained, the bones being removed, and the balance (with which sometimes meat is mixed) is made into balls and preserved in the liquid previously strained off. These balls and liquid are called Rehahakaroo.

As to Isolation, Dr. Beech continues, " It is the religion of the islanders, that all those suffering from leprosy should be segregated and the power of segregation rests with the Khazi. . . . The Khazi informs me that since he has been priest (fifteen years) he has noticed a slow but sure tendency to the spread of leprosy. He imagines that he sends all those suffering from the disease to the settlement. The segregation in the retreat seems to be strictly maintained." It is added :

" It is the duty of the Khazi, or priest, to determine if the patient is suffering from leprosy in either of its various forms, and should they be affected, they are sent to the northern part of the island, and a boundary line is drawn across the island, separating them from the village of Minicoy, and over this boundary they are not allowed to pass ; at the same time the inhabitants are forbidden to go into their settlement. Before a leper is sent to join the main body of lepers, there is a period of probation of uncertain length of time, during which time those under observation are detained in a small hut within the settlement, but away from the main body of lepers. These poor lepers are fed by their relations, who place food daily, or twice or three times a week, just within the settlement boundary. There must be times when they are very poorly provided for."

It must be pointed out that these facts are supplied by one who was not an advocate of the fish origin of leprosy. Despite the statements which we have quoted and which appear, at first sight, to point in that direction, Dr. Beech remains unable to assign any special cause for the disease. This negative attitude of mind appears to have resulted from the observation that only the poorer classes suffered from leprosy, whilst rich and poor alike eat fish. The population of three thousand consists of :—

Malikans, or " aristocrats," who are free from leprosy.

Malummis, who are pilots, sailors, &c., and live much away from home, and are also free. °

Klasies or Thakrus, the agricultural and gardener class, who live at home and also engage much in fishing. They suffer from leprosy.

Malacheries, the toddy drawers.¹ They suffer very severely from leprosy.²

The two latter classes do not, as a rule, intermarry with the two former and they are the least prosperous part of the population, and almost exclusively the sufferers from leprosy. Although, as Dr. Beech expressly states, the two upper classes have a greater variety of food, he yet asserts that they eat the same kind of fish and infers that if fish were the cause they also ought to suffer. It may be asked, however, whether he was quite sure as to his facts. Possibly they do not eat the worst kinds of fish, and, possibly, they are not absolutely free from leprosy.

It is of much interest to note how closely the conditions now existing in Minicoy correspond with those found in Norway a century ago. At that time the aristocracy of Norway did not suffer, it was the peasants and fisher class almost exclusively. At that time the latter class used, as its animal food, fish almost exclusively. As in Minicoy, those who suffered were a vigorous race of men, against whose general physique nothing could be alleged. Contrary to the rule in most parts of the world, women in Minicoy suffer from leprosy in greater proportion than men. Fifty years ago the same statement was made as to Norway, although it is not so now. It is not difficult to give a plausible explanation of this apparent discrepancy. All the world over, in matters of food, it is to be feared that men are a selfish sex. Where cured fish is dear and a luxury, the men get most of it, but where it is an article of daily food, the

¹ The toddy drawer in India is not a barman, and has nothing to do with whiskey. His vocation is to collect the sap of the palm tree.

² It is a little difficult to follow Dr. Beech's figures without risk or error. He writes, "Leprosy in these islands is confined to two classes alone, the Malacheries and the Thakrus; of the former there were 38, and of the latter 20 attacked." No information is given as to how these figures were arrived at or to what period of time they include. Under the head of statistics he gives Thakru and Malumis, men 432, women 519; Malacheries, men 265, women 328." If this means that out of a population of 573 Malacheries 38 were lepers, it gives the enormous ratio of 600 per 10,000. There has, however, never been any satisfactory census either of the population or of lepers, and although we may take it as proven that leprosy is terribly prevalent it will be safest to avoid any attempt at exact estimates. Twenty would appear to have been the average number of inmates of the leper settlement, but Dr. Beech says that many were still at their homes.

women get the worst quality and they are more nearly restricted to it than are the men.

Of the inmates of the leper settlement at the date of Dr. Beech's report, nine were men, and ten women; fourteen were of the Malacheri class, and five were Thakrus.

In answer to those who might suggest that the two upper classes are exempt from leprosy, because, from not associating with the others, they escaped the risk of contagion, Dr. Beech replies that they often employ leprous servants. Indeed, on a small island, it is unreasonable to suppose that any particular class could long remain wholly free from a disease which was really contagious. We would suggest that the obvious inference from the facts which we have passed under review is that segregation is quite useless where the food supply conduces to the *de novo* production of the disease. It will, of course, be suggested that the Khazi's isolation is not efficient. This is very true. Many lepers in Minicoy are still at their homes. But it is just the same in Norway, and it was much worse than the same in Europe during the Middle Ages.

J. H.

TWO CENTURIES OF ENGLISH SURGERY.

IN 1702 Daniel Turner, the author of "The Art of Surgery," and of Treatises on Syphilis and Diseases of the Skin, and whose motto was *in verba nullius*, wrote to his friend Mr. Charles Bernard a letter "On the present state of Chirurgery." In it occurred the following genial expressions:—"I can't persuade myself but that the art of chirurgery is, at the present time, in a more flourishing state than ever, and am inclined to believe that the city of London can produce a greater number of men eminent in that profession than any other in the world." At that date neither Pott nor Hunter had been born.

In 1802 Hunter had been dead nine years, and the influence of his teaching was in course of realisation. Certainly English Surgery had maintained its ground.

Nor can we, in 1902, with the discoverer of Aseptic Surgery fortunately still with us, and the memory of Paget fresh in our minds, admit that there has been any falling back in the race. Rather may we not, with thankfulness, repeat Daniel Turner's modest boast.

MODERN TRIUMPHS AS TO CANCER.

WHEN the public twits our profession that we know nothing as to the nature of cancer, and have found no cure for it, a gross injustice is unwittingly committed. The past half-century has witnessed most important advance in our appreciation of the nature of cancer, and following on this great strides have been taken both in its prevention and its cure. Thousands of persons are now every year saved from death from cancer who would in former times inevitably have died of it. The first great step was the recognition that almost all cancers are in their early stages strictly local, and, if freely removed, they will not return. The next was that there is in many instances a pre-cancerous stage, during which a timely operation may be the means of preventing the development of the disease. Going a little further still, it has been recognised that certain local causes of irritation may induce this pre-cancerous stage, and we are now careful to warn our patients against them.

It is true that no drug has been discovered which can do much in controlling the cancerous process, and that many forms of the disease are not amenable to treatment by the knife. It is true also that our triumphs have been those of clinical observation and common sense rather than of "scientific methods," and that, with sorrow be it spoken, the microscope has hindered rather than helped. It is further to be admitted that the sum total of cancer mortality has increased rather than diminished. In spite, however, of these admissions, it remains the fact that we have gained much insight, achieved great triumphs, and that there is good reason to believe that we are on the road to more.

OUR COMPOSITE COURSE OF LECTURES.

NEARLY half of the Winter Series of our new Course of Lectures on the Practice of Medicine and Surgery have now been given. They have proved successful beyond expectation. The class has varied from sixty to near one hundred, being probably one of the largest ever secured for such an object. Sir William Gowers was kind enough at twenty-four hours' notice to take the place of the lecturer who had been announced for the first of the series, and who was prevented by indisposition. After him followed Sir William Broadbent with crowded audiences. Dr. Colcott Fox on "Impetigo" and Dr. Judson Bury on "Peripheral Neuritis," both of them succeeded in interesting and instructing a class-room full to overflowing of those well qualified alike to judge of what was brought before them and to profit by it. They will be followed by Mr. Keetley on "Coxa Vara," and Dr. Manson on "Dysentery."

Arrangements are now being made for the continuation of this Course next year, and many good names are already on our list. The programme, which will shortly be announced, will probably extend over the whole year. With the new year there may also be expected some modification of the fees at present payable. At our existing almost nominal rates the current expenses of the Institution are not adequately met. We have no wish to accumulate wealth, but it will be obvious to all that it is essential that our income should cover our outlay, and that those who profit should provide the funds. The changes which are contemplated will not be onerous to anyone.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

SYPHILITIC DISEASES OF THE NERVOUS SYSTEM.

BY SIR W. R. GOWERS, F.R.S.

[*Abstract.*]

SIR W. GOWERS said that he appeared at short notice as a substitute for Mr. Hutchinson, who had been announced to lecture but, having been prevented, had asked him to take in his stead Syphilitic Diseases of the Nervous System. He had, unfortunately, not told him what to say. He could, therefore, only give them a sketch of old knowledge, but the old was not to be despised. We know nothing of true syphilitic processes affecting the nerve elements themselves, and curable by the customary methods. It is the supporting neuroglia, the membranes which blend with it, and the walls of the vessels, which form the seat of essential syphilitic changes in the nervous system. But these changes are never the direct cause of the symptoms. The symptoms are always due to secondary consequences in the nerve elements—consequences which are simple in nature and such as any other disease in the same situation would cause. A gumma pressing on the spinal cord causes paraplegia by pressure changes in the same as any other tumour. Syphilitic arterial disease narrows the vessel, the calibre of which is closed by a simple clot, and the resulting softening which produces the symptoms is an ordinary softening without any special or peculiar characters. The problem of syphilitic inflammations is more difficult, because in these we seem to have a combination of simple inflammation with the specific factor, and the former pre-

ponderates in proportion to the acuteness of the process ; in the more chronic it may be difficult to say whether the process is gummatous inflammation, or a gumma with adjacent inflammation.

These considerations have an important practical bearing on prognosis. It is important to cultivate the pathological imagination and the habit of making a mental picture of the state in every case. They make clear an important rule, to which exceptions are rare, that the more rapidly symptoms are produced by organic disease of syphilitic origin, the less influence has the specific factor on the prognosis. It is marked in paraplegia from pressure ; it is hardly tangible in softening from arterial closure. Most cases of this latter improve, as do most cases of embolism, but not from the treatment, necessary as this is to remove the similar disease in other vessels, but it cannot renew the circulation in a closed artery or the life in necrosed tissue. In inflammation, no treatment can restore destroyed nerve elements, but the damage is often short of destruction and much may therefore be done, but here, also, the prospects are in inverse proportion to the acuteness of the process.

The nerve elements themselves suffer from syphilis, but only by a slow degeneration, not influenced by specific treatment and probably due to a post-syphilitic toxin. Not only does energetic treatment fail to do good, it may even accelerate degeneration or induce a fresh degeneration. These degenerations are best explained as the effect of a toxic agent, possibly the result of a permanent change in some vital chemical process. But there are cases in which the period of a true specific process overlaps that of a post-syphilitic degeneration, and for these, of course, treatment is necessary.

Such treatment is by mercury and potassium iodide. Modern discovery has not added to these. Sir William urged strongly that the medicinal treatment should be energetic and brief. It is useless to use mercury (except in minute doses as a tonic) unless to such a degree that the gums are affected ; elimination varies in different persons, and, unless mercury is pushed so as to produce a physiological reaction, we do not know that enough is retained in the blood to influence the tissues. No method is so good as inunction. Hypodermic injection has no advantage. A very slight affection of the gums should be obtained in ten days and kept up for three

weeks. Iodide of potassium should be given afterwards, not simultaneously, as it promotes elimination. It may, however, be given for a few days at the beginning when the need for energetic action is urgent. If the iodide has not been taken before, ten or fifteen grains three times a day will remove symptoms as promptly as is conceivable. But neither iodide nor mercury should be continued for more than six or eight weeks. In that time they will remove all the true specific element; the simple damage may take longer to heal, and, therefore, persistence of symptoms does not mean persistence of the essential syphilitic process. On the other hand, Sir W. Gowers has known the administration of ten grains of iodide three times a day remove promptly all symptoms of a cerebral gumma, and yet, though continued for several months, fail to prevent the development, during the course of the treatment, of a gumma of the spinal cord. He has also known the same thing occur under mercury. Hence he believes it most important that the administration of iodide should not be continuously sustained over a long period, but should be periodically repeated for two or three weeks every four or six months for some years, whether the patient has symptoms or not. It is better to prevent than to cure, and this applies equally to the symptomatic manifestations of a disease as well as to the diseased process itself.

THE SYMPTOMS AND TREATMENT OF ACUTE APPENDICITIS.

BY H. GILBERT BARLING, B.S., F.R.C.S.

[*Abstract.*]

IN his introductory remarks Mr. Barling expressed the opinion that the more frequent recognition of appendicitis was due not merely to greater accuracy and precision in diagnosis but to an actual increase in the number of cases. He attributed this increase, in part, to the more common existence of indigestion as the result of imperfect mastication and of constipation—conditions for which the hurry and drive of modern life must be held largely responsible.

Another etiological factor is possibly to be found in the recent epidemics of influenza. The presence of imperfectly digested food in the bowel is likely to lead to mucous catarrh of the colon; and chill, more especially in gouty people, may readily produce the same result. Should the appendix be involved in the catarrhal process, obstruction, as by a faecal stone or a kinking of this part of the gut, will mean the retention of inflammatory products and the risk of extension to the peritoneum. Such a conséquence may be rendered more probable, either by some peculiar anatomical form or arrangement of the appendix, or by an individual susceptibility to the influence of particular micro-organisms, and one or other of these circumstances may be advanced in explanation of the tendency which appendicitis not infrequently displays to attack several members of the same family.

To find a comprehensive, and at the same time an exact definition of what constitutes an attack of appendicitis is not easy. The seizures in different cases vary so widely both in character and degree that no short phrase can be found to include them all. But in general terms an attack of acute appendicitis may be said to be characterised by (1) pain which at the onset is referred to the umbilical, the right iliac, or occasionally, to the left iliac region; (2) elevation of temperature, quickening of the pulse, and other signs of febrile disturbance; and (3) evidences of local peritonitis tending to spread more or less widely and rapidly. The dominating clinical fact is the occurrence of peritonitis starting from an inflamed appendix and extending by the widening invasion of infective micro-organisms. The degree and extent of the peritonitis vary widely in different cases. It may be a mere localised plastic inflammation attaching the appendix by adhesions to neighbouring parts. It may, on the contrary, go on to suppuration and the formation of an abscess, and this may either be adherent to the abdominal wall, so as to be readily evacuated by incision, or may be in some other position where its isolation from the general peritoneum is much less secure and its surgical approach is more difficult. Again, the suppuration resulting from the peritonitis may be diffused rather than in the form of a localised abscess and may thus extend in various directions, as into the pelvis, or the upper parts of the abdomen. And lastly, and worst of all, the inflammation may

rapidly spread from the appendix through the whole of the peritoneum, and the condition may thus promptly be one of diffuse acute peritonitis. Reviewing a total of 143 cases treated by operation in his own practice, Mr. Barling stated that the percentage of deaths was 17·5, but he was convinced that delay in the adoption of surgical measures was a considerable factor in determining the high level of this mortality. He pointed out, further, that for purposes both of prognosis and treatment it was necessary to discriminate between different cases according to the character and degree of the accompanying peritonitis. Thus in 29 cases attended with diffuse peritonitis there had been 14 deaths; in 34 instances of suppuration extending into the pelvis or other parts the deaths had numbered 7; in 49 examples of abscess, non-adherent to the abdominal wall, all had recovered save 2; and in 31 cases in which the abscess was adherent and relatively safe there had also been only 2 deaths. These figures show how very necessary it is in discussing the treatment of appendicitis to distinguish the various groups of cases. Those attended with rapid and intense general peritonitis—fortunately an infrequent variety—undoubtedly demand immediate operation. The same is true when an abscess that has been localised in the neighbourhood of the appendix bursts into the cavity of the peritoneum—a disaster that may be produced by the manipulations of the surgeon. But such occurrences cannot be advanced as an argument for immediate operation on cases in which the conditions are entirely different. Hence, in the other groups as defined above, the indication is to endeavour to carry the patient through the inflammatory attack with a view to operation in the more favourable circumstances of a quiet interval. The presentation of a definite general rule in regard to the claim for operation is not possible, but the following considerations afford the main directing indications:

(1) *Pain*.—An intense agonising pain of sudden onset and attended by signs of collapse is exceptional, but it is a sign of great urgency and demands operation. More often the pain, though severe at the outset, becomes less in the course of a few hours, and in these circumstances the surgeon should hold his hand. There may, however, be a sudden and severe aggravation of pain rendering surgical interference probably necessary. It is these possibly rapid

variations in the aspect of the case which make it imperative for the practitioner to see the patient at frequent intervals, more particularly in the early stages. And even when progress is favourable, and the patient appears to be convalescent, there may be a recrudescence of the inflammation and the case thus assume an urgent aspect.

(2) *Vomiting*.—Alarm is associated with this symptom when it persists in spite of some hours of *absolute* starvation. In these circumstances there should be no delay in opening the abdomen whatever be the state of the pulse or temperature. Vomiting, even though persistent, when solids or fluids are being given by the mouth is not necessarily a claim for operation. In some cases vomiting does not occur, but this, *per se*, is not a basis for a favourable prognosis unless all the other features of the case also point towards a hopeful outlook.

(3) *Tenderness*.—Extreme tenderness means a serious condition below the tender surface. Like pain, it varies in degree, and its variations have much the same significance as those attached to changes in the severity of the pain. It is not the case that McBurney's point is always the site of greatest tenderness. The same is true of the right iliac fossa. The maximum degree of tenderness may even be in such situations as the loin, the pelvis, the upper abdomen, or the left iliac region.

(4) *Muscular Rigidity*.—When extreme this is of bad import. The rigidity is often mistaken for a "lump," which, as a matter of fact, can only be detected as the rigidity subsides. The recognition of an undoubted lump or swelling is an indication that the case is not very urgent. In the very worst cases there is no localised swelling.

(5) *Percussion*.—This method of examination does not give any reliable information. Even with a large collection of pus a clear note may be obtained, either in consequence of the bowel lying in front of the abscess or as a result of the presence of gas in the abscess cavity.

(6) *Pulse*.—This on the whole is the best guide, though neither it nor any other one sign, taken alone, is decisive. As a rule the pulse is quick, soft and yielding, the rate tending to fall as the pain subsides. A sustained rapidity even with diminution of pain, and still more a steadily increased rate, though the temperature at the the same time is falling, is a fact sufficient to justify operation.

(7) *Temperature*.—A temperature following the hectic type and persisting for a few days may be taken as a fairly definite proof of the formation of an abscess. But pus may exist with little or no elevation of temperature. Hence, whilst a definite pyrexia is of considerable value in discussing the necessity for operation, the absence of fever ought not to be urged against operation if other circumstances suggest the advisability of surgical treatment.

(8) *Leucocytosis*.—A considerable leucocytosis, and more especially one which successive observations show to be increasing, is an almost unqualified demand for operation. With a falling leucocytosis, on the other hand, the surgeon may wait, unless other circumstances are unfavourable. But the absence of a definite increase in the leucocyte count is not a safe ground for postponing interference when other signs suggest surgical necessity. Concerning all the above it should be borne in mind that one or two bad signs are of more importance than several good ones. Action must be based on the former not on the latter. A single positive indication of danger must not be pushed to one side on the ground that other facts seem free from the suggestion of alarm.

In conclusion, Mr. Barling described the method of operating in the various classes of cases and discussed the question of the removal of the appendix. Speaking on the general treatment he allowed that it was often, or even generally, impossible to avoid the use of morphine at the outset of an attack of appendicitis. In these circumstances he advised a single full dose, say one-third grain by hypodermic injection. If in spite of this pain persisted for two or three hours it might be allowable to give a second dose, though the mere necessity for this was a ground for some anxiety. But no further administrations should be permitted. Persistence of the pain in such circumstances is a claim not for more morphine but for the intervention of the surgeon.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY SIR WILLIAM H. BROADBENT, BART., M.D., F.R.S.

Cases of Cardiac Disease.

IN the first of these, a woman in middle life, the question at issue was the interpretation of the auscultatory phenomena observed in the examination of the præcordial region. The existence of a loud, rough murmur accompanying both the ventricular systole and the ventricular diastole was readily appreciated, but the clinical interpretation of these murmurs was less obvious. The use of the binaural stethoscope failed to establish a conviction as between a double aortic murmur on the one hand and a to-and-fro pericardial friction sound on the other. As against the diagnosis of aortic disease Sir William Broadbent directed attention to the absence of any visible pulsation in the arteries of the neck and to the non-existence of anything suggesting "the water-hammer pulse" in the radial arteries. Speaking on the value of pressure with the stethoscope as a means of differentiating endocardial from pericardial murmurs, he said that both classes of murmurs were more or less modified by pressure, though those of pericardial origin display this character in the higher degree, and with these the change may be in the direction either of increased or diminished distinctness. Applying this test to the present case, and using for this purpose the ordinary wooden stethoscope, it was shown that a very considerable modification of the murmurs was produced by moderately forcible pressure, and this was urged as a further fact in favour of a diagnosis of pericarditis. Lastly, Sir William demonstrated a method of establishing the diagnosis on which he said considerable reliance may be

placed. This consists in listening to a murmur through the wooden stethoscope and then removing the ear a short distance from the ear-piece, so that a narrow column of air intervenes between the two. If in these circumstances the murmur can still be heard, there is a strong presumption that it is endocardial in origin, whereas if it fails to reach the ear the probability is that it depends on pericardial disease. In the patient under observation this test also favoured a diagnosis of pericarditis; and, taken together with the other facts already mentioned, removed the uncertainty as to the source of the murmurs which unaided auscultation had failed to dispel.

A second patient was a man of 27 years in whom a pre-systolic murmur and other physical signs of mitral stenosis were easily detected. In addition—and this was the special feature of the case—a soft diastolic murmur was present over the pulmonic area and could be traced downwards to the lower half of the sternum. Here again, therefore, the point at issue was the clinical significance of a cardiac murmur, and the question to be decided was whether regurgitation at the aortic or at the pulmonic valve was the cause of the diastolic murmur just described. It was admitted that the majority of diastolic murmurs are of aortic origin and that such murmurs are occasionally heard most distinctly, as here, in the third left intercostal space rather than in the aortic area. But it was pointed out that the present murmur in the area of its distribution corresponded exactly to the pulmonic regurgitant murmur, and further, that there were no other physical signs of aortic regurgitation—no hypertrophy of the left ventricle, no throbbing of the carotids, and nothing of the collapsing character in the radial pulse. Additional support for the diagnosis was found in a comparison of the aortic and pulmonic sounds. In the aortic area the second sound had its ordinary character, but to the left of the sternum the sound was much accentuated. The inevitable inference was that the arterial tension in the pulmonic circuit was greatly increased and thus produced forcible closure of the pulmonic valve, a result, doubtless, of the obstruction at the mitral orifice. In such circumstances it is not difficult to picture some defect in the accurate adjustment of the cusps of the valve, slight perhaps, yet sufficient to permit a slender stream of blood to regurgitate into the right ventricle and to produce a diastolic murmur. The argument, therefore, is

that the site of the murmur is in harmony with a diagnosis of pulmonic regurgitation (allowing that this consideration alone does not exclude the possibilities of aortic regurgitation); that the characters of the pulse, the non-existence of visible pulsation in the carotids, and the non-enlargement of the left ventricle oppose the theory of aortic regurgitation; that the sharp and loud character of the second sound over the pulmonic area show a condition of high tension in the pulmonic circuit dependent without doubt upon mitral obstruction; and that such facts are adequate to produce leakage of the pulmonic valve with its usual clinical expression in the shape of a diastolic murmur.

A Case of Aneurysm.

This case was an example of aneurysm affecting probably the transverse and descending parts of the arch of the aorta. One of the most striking facts was the almost entire obliteration of the pulse in the left carotid and subclavian arteries; without, however, any recognisable interference with the supply of blood to the limb. The hand was warm and natural in colour, and the radial artery could be felt full of blood, though there was no pulsation in it. Below the inner third of the left clavicle was an area of dull percussion over which the second cardiac sound had a loud, dull character, and this was insisted on as a fact of much diagnostic value. Pulsation over the site of the aneurysm, though of somewhat wide extent, was inconspicuous, and it was presumed that this was a favourable index as showing thickening of the aneurysmal wall by the deposition of fibrin on its deep surface. The chief symptom was pain, which took origin in the chest and extended into the left upper limb and left thigh.

Other cases included (1), a boy of 15 years complaining of breathlessness on exertion, found to be due to an enlargement of the isthmus of the thyroid gland pressing on the trachea, and (2), two patients with early physical signs of pulmonary phthisis; in one conspicuous *myoidema* was readily elicited, and Sir William Broadbent said that this was a fact of much value in the diagnosis of phthisis pulmonalis, being often found when the physical examination yielded more or less doubtful results.

BY HARRY CAMPBELL, M.D., F.R.C.P.

A Case of Toxæmia (?)

The patient, a woman of 27 years, gave a somewhat extraordinary history. Without any known cause, and some six weeks ago, she became aware, somewhat suddenly, of failure of power in her limbs, not to such a degree as to confine her to bed, but quite sufficient seriously to incapacitate her. About ten days after this time she experienced a considerable amount of pain in her limbs, and this was soon followed by a high degree of swelling which, when she came under observation, involved all four limbs, and was œdematous in character. There was also a wide-spread eruption over the skin, not of an urticarial type, and the skin generally was free from any evidence of diffuse inflammatory reaction. These facts, and the existence of an inflamed aphthous state of the buccal mucous membrane, were the only positive results of a physical examination. There was no albumen in the urine, and not the slightest evidence of any organic disease in the thoracic or abdominal viscera. Discussing the case, Dr. Campbell alluded to the absence of any suggestion of urticaria in the skin eruption, and to the non-inflammatory character of the swelling. To him this had appeared, with the doubtful exception of that seen in the neighbourhood of the elbows, to have exactly the features of a passive dropsy, such as is common in cardiac and renal affections. He suggested that in view of the absence of all signs of organic disease, and of the prompt and complete recovery of the patient, the case must be looked upon as one of toxæmia, though there was nothing to show either the nature of the poison or how it had gained admission to the body.

Facial Paralysis from Middle-Ear Disease.

A man of 22 years was shown with a unilateral facial paralysis (Bell's palsy), associated with a history of purulent discharge from the ear. Dr. Campbell discussed the anatomical relationships of the facial nerve in reference to ear disease, and pointed out the clinical differences between facial paralysis due to a lesion of the nerve and that dependent on a cerebral lesion.

Scleroderma or Myxædema (?)

A stout, florid woman of middle age complained of a hard, tight feeling of the skin over her chest, and examination detected the wide distribution of a firm, thickened state of the integuments both over the trunk and the limbs. Above the clavicle on each side was a considerable, firm, rounded prominence. The diagnosis gave rise to some discussion as to whether the case should be named one of scleroderma or myxædema.

There were also shown two cases of *tabes dorsalis*, in one of which a perforating ulcer had been present on the plantar aspect of the great toe for at least six years.

Atrophy of Hand Muscles following Injury of the Spinal Cord.

This was a case in which atrophy of the small muscles of the hands was exhibited in a very extreme degree, the thenar and hypothenar eminences and the interossei muscles all being much wasted. The condition was bilateral and symmetrical, and the atrophy was the more conspicuous owing to the well-nourished condition of the muscles of the forearms and the generally healthy appearance of the patient. Taken alone, the hands might have been offered as a picture of advanced progressive muscular atrophy. The limitation of the distribution of the wasting was, however, sufficient in itself to call for some other explanation. This was supplied by the history, which also contributed an additional feature of interest to the case. It appears that the patient—now a well-grown young woman of 19 years—was, when five years of age, run over by a cab, the wheel of which, it is said, passed over her neck. Shortly after the accident the muscles of her hands began to waste, and they soon reached the advanced atrophic condition which they now display. Thus the history suggests a central lesion, and this is supported by the bilateral symmetrical distribution of the atrophy. Further, the extreme degree of the atrophy proves that the trophic influence of the spinal centres has been cut off from the muscles. Hence it must be concluded that the site of the lesion is in the anterior cornua of the grey matter of the spinal cord. And the circumstances in which the injury occurred, taken together with its manifestly restricted extent, carry without much hesitation the

diagnosis of hæmorrhage. The noteworthy facts in this aspect of the case are (1), that violence applied to the cervical spine has been capable of producing a practically complete destruction of a limited group of spinal nerve-cells without injury to neighbouring centres, and (2), that such destruction has occurred at corresponding points in each of the anterior cornua.

An Example of Small White Kidney.

Dr. Campbell showed a *post-mortem* specimen of the small white kidney removed from the body of a woman 28 years of age. According to the history of the case the patient had regarded herself as in good health until six months before death. At the date mentioned she began to complain of occipital headache, and, shortly after this, of morning sickness and failure of vision. When admitted to hospital she was found to be anæmic, with some measure of pigmentation of the skin ; there was cardiac hypertrophy and a high tension pulse ; the urine contained a considerable quantity of albumen ; and the ophthalmoscope showed characteristic changes in each fundus oculi. Subsequently she became completely blind, and died in uræmic convulsions. In commenting on the case, Dr. Campbell alluded to the occurrence of the disease in young adults as compared with the development of chronic interstitial nephritis (small red kidney) in or after middle life. In each disease the symptoms are similar, but in the case of small white kidney the amount of albumen in the urine is large, and the immediate prognosis is much more serious. The tendency to the development of uræmic phenomena is marked, as the record of the above-recorded case shows. The changes in the kidney are not sequels of acute or chronic parenchymatous nephritis, but are the consequences of irritation of the renal tissue by toxins produced by faulty metabolism. It is these toxins also which explain the existence of the high blood pressure, and it is to be noted that this increased blood tension may be observed before the occurrence of albuminuria signals the fact of structural disease of the kidney substance.

The Value of Babinski's Sign.

Babinski's sign, that is, hyper-extension of the great toe with flexion of the other toes on mechanically stimulating the sole, was

demonstrated in the case of a youth showing exaggeration of the knee-jerks and ankle-clonus. Dr. Campbell said that this sign was conclusive proof of organic nervous disease involving interruption of the pyramidal tract. Hence it is of considerable value in distinguishing organic hemiplegia and paraplegia from the functional varieties of paralysis. Hysterical conditions are often accompanied by increase of the knee-jerks and even by a *quasi*-ankle-clonus. But they never cause Babinski's sign, which is, therefore, a clinical fact of considerable diagnostic moment.

An Example of Intra-Uterine Amputation.

The patient was an infant of 9 months, born minus two fingers on the right hand. In addition, there was a deep, circular, cicatricial constriction of the soft tissues at the junction of the middle and lower thirds of the right leg.

Other cases included (1), an early example of paralysis agitans; (2), a woman, aged 53 years, with right hemiplegia and complete motor aphasia; (3), a man with "dropped wrist," due to lead poisoning; and (4), several examples of deformity of the upper jaw consequent on nasal obstruction in childhood.

SURGICAL CASES.

BY REGINALD HARRISON, F.R.C.S.

Bladder Drainage.

MR. REGINALD HARRISON continued the subject of bladder drainage (from September 17) and demonstrated by drawings (which were given to each member of the class) and from patients who were introduced, its application to cases of acute extravasation of urine, and of urinary fistula. In the former group he wished particularly to insist on the recognition of the necessity for (1), the removal of the stricture in the urethra by an internal urethrotomy,

and the provision of direct and free drainage by a perineal opening with the insertion of a suitable gum-elastic drainage tube into the bladder; and (2), the liberation of the urine by incision wherever swelling, tension, air-crackling, or redness indicated that it had been extravasated. The examination of many patients had convinced him that the central perineal incision, where the leakage from the urethra usually first occurred, often failed by itself to provide the requisite incontinent drainage, as extravasation not infrequently continued to go on after this incision had been made. Opening the urethra immediately in front of the prostate did not necessarily secure even temporary incontinence of urine as after lateral lithotomy. In the former case the introduction of a properly constructed and fitted drainage tube not only provided incontinent and continuous urine drainage but furnished a guarantee that further extravasation would be prevented. But little reliance can be placed on the incisions made to liberate extravasated urine into the tissues as drains, by reason of these routes often being circuitous and liable to be blocked by pus or sloughs. The central perineal main drain should, therefore, not be omitted. He also urged that where incisions were made to liberate extravasated urine, as for instance in the scrotum, which was often enormously tense and swollen, the urine should be squeezed or pressed out with the hands in the manner that a wet sponge is rendered dry. In this way much extravasated urine could be immediately expelled, and sloughing and loss of tissue prevented. In making incisions to liberate extravasated urine care should be taken to place them, if possible, where, neither in their healing nor cicatrizing subsequent trouble is likely to be caused. A case was mentioned, where, in this way, a part of the dorsum of the penis became connected with the suprapubic surface.

In reference to the treatment of urinary fistula, cases were shown where the healing of these sinuses had speedily followed the employment of perineal drainage as described. In these instances the complete withdrawal of the urine by drainage had been sufficient to ensure the entire obliteration of the sinuses.

Three patients were shown and their cases discussed, namely, (1) extravasation of urine, (2), numerous urinary fistulæ under treatment by perineal drainage, and (3) a patient, aged 67, nine months after prostatectomy by enucleation—complete recovery.

DISEASES OF THE EYE.

BY H. WORK DODD, F.R.C.S.

A Case of Night Blindness.

THE patient was a young woman who complained that during the last few months she had had great difficulty in seeing in the dusk of the evening, and this to such an extent that she frequently fell over articles of furniture, etc. The external examination of the eyes showed no abnormality, and the ophthalmoscopic examination was also negative. Perimeter tracings, however, gave a decided contraction of the visual fields. Mr. Work Dodd alluded to the association of night blindness with *retinitis pigmentosa*, the characteristic feature of which is the presence in the periphery of the retina of abnormal pigment distributed so as to resemble the lacunæ and canaliculi as seen in a microscopic section of bone. In this affection, also, the optic disc has a peculiar greyish-yellow colour, and the retinal arteries are narrowed. All these features were absent from Mr. Dodd's patient. There was no pigmentation of the retina even in the extreme periphery, the optic disc had a healthy appearance, and the retinal vessels were of normal calibre. Hence it seemed impossible to attach to the patient the diagnosis of *retinitis pigmentosa*, at least without adding the contradictory qualification *sine pigmento*. All the same, this statement may be taken as indicating a possible development of the case. It may be, that is to say, that the characteristic pigmentation will appear at a later date. On the other hand, it does rarely happen that a patient suffers from night blindness and has a limited field of vision without at any time any abnormal retinal pigmentation, and the exact relationship of these cases to cases of *retinitis pigmentosa* is somewhat uncertain. All that can with confidence be said about the present case is that, without any ophthalmoscopic change to account for it, the peripheral portion of each retina is defective in its power of response to stimulation by light. Hence the field of vision is contracted, and as the defect is most marked when the illumination is poor, the patient experiences special difficulty in guiding

herself about at night. Whether there will be at a later date the fundus changes which distinguish retinitis pigmentosa is a matter of speculation. If such should prove to be the case, the outlook is not an encouraging one. The pigmentary changes which in this condition commence in the periphery gradually invade the central portions of the retina, and the visual field becomes more and more contracted. Central vision, however, may for long remain good, and complete blindness is often postponed for many years.

A Case of Traumatic Enophthalmos.

Enophthalmos is the opposite condition to exophthalmos or proptosis. It is applied to the condition in which the eyeball recedes within the orbit. Some degree of it may appear as a consequence of absorption of the intraorbital fat, as seen in extreme emaciation, in which case, of course, the recession occurs on both sides. Unilateral enophthalmos is sometimes a congenital condition, or it may be a result of the removal of an intraorbital tumour; paralysis of the sympathetic may also cause it. In other instances it follows a blow. Mr. Work Dodd's patient was an example of this last association. As is usual in such cases, the eyeball itself was uninjured. The actions of the several muscles, too, were perfect. But a month or so after being struck on the cheek by the shaft of a cab, patient observed that the eyeball was beginning to sink in the socket, and this had now reached such a degree as to readily attract attention. The explanation of traumatic enophthalmos is not a very confident one. It may possibly be due to some change in nutrition leading to absorption of fat. Another suggestion is that it is a consequence of contraction of cicatricial tissue formed within the orbit as a result of the injury. By some authorities it is taught that in these cases there is a fracture of the floor of the orbit, and that this is depressed into the antrum of Highmore; hence the orbital cavity is enlarged, and the eye retreats within it. By others, traumatic enophthalmos is explained as a result of nerve injury.

Recurrent Third Nerve Paralysis.

The association of an ocular paralysis with central nervous disease, more particularly with tabes dorsalis, is by no means in-

frequent and has often been illustrated in our clinics. A young man, shown by Mr. Work Dodd, proved to be an example of this association, and further, his case emphasised the fact that such paralyses may be of temporary duration, and may recur again and again. The disappearance of the paralysis cannot, unfortunately, be interpreted as a sign that the tendency to central nervous disease has come to an end. The patient was first seen in August, 1900, when he had paralysis affecting the whole of the area of distribution of the left third nerve. There was no doubt that he had had syphilis, and under the use of mercury and potassium iodide his ocular paralysis completely disappeared. According to his own account he enjoyed good health until March, 1902, when he returned to the hospital with paralysis of all the branches of the right third nerve. Again, under treatment, the paralysis disappeared, so that at the present date, except that the upper lids droop somewhat, there is no room for adverse criticism of the actions of the ocular muscles. But there is, unfortunately, sure evidence that degenerative changes are advancing in the central nervous system. For it is now found that the patient has lost his knee-jerks, and that there is distinct swaying of the body when he stands with his eyes shut and his feet close together.

A second case of ocular paralysis was that of an elderly woman who had all the marks of a third nerve paralysis on the right side. There was complete ptosis; the eyeball was turned downwards and outwards, and could not be moved from this position; and the pupil was dilated and immobile. The history showed that seven years ago the patient had a similar attack affecting the same eye, and that from this she made a complete recovery. There was no evidence of specific disease, and, though the suspicion of syphilis cannot be excluded, it is quite possible that the paralysis is open to some other interpretation.

Nystagmus and Disseminated Sclerosis.

This patient, a girl of about 20 years, had gone to the ophthalmic hospital on account of the condition of her eyes. She was the subject of marked horizontal nystagmus, the rhythmical movement being especially distinct when the patient was made to look to the

left side. Just as in each of the two previous cases a suspicion of central nervous disease arose from the fact of an ocular paralysis, so here a similar suspicion was suggested by the nystagmus. Examination showed that the patient had marked intention tremor in the upper limbs, and that the knee-jerks were exaggerated; ankle clonus was also present. Thus there could be no hesitation in applying the diagnosis of disseminated sclerosis. Nystagmus is a result of many conditions other than this disease, but when combined with the above-mentioned symptoms there can be no doubt of its significance.

Other cases included (1) examples of interstitial keratitis; (2) a case of hypopyon keratitis; (3) a patient with colour blindness, and (4) several examples of glaucoma.

BY ERNEST CLARKE, M.D., F.R.C.S.

Examples of Irido-Cyclitis.

MR. ERNEST CLARKE first exhibited a series of cases to illustrate the various forms of *irido-cyclitis*.

The first patient, a stout middle-aged man, was shown as an example of what used to be termed *serous iritis*. There was marked tenderness of the globe, œdema of the upper lid, considerable circumcorneal injection, a dull discoloured iris, and evidences of adhesion of the iris to the anterior capsule of the crystalline lens. There were none of the scattered opaque deposits on the deep surface of the cornea often named *keratitis punctata*. The most prominent symptom had been pain, and this had been very extreme. Leeches to the temple had been used with great benefit. The other features of the local treatment had been atropine and boric acid fomentations. Internally, purgatives had been ordered, and salicin and iodide of potassium had been prescribed on alternate days.

In a second case the iritis was relatively slight whilst the inflammation of the ciliary body (cyclitis) had been severe. This was shown by the abundant deposit on the deep surface of the

cornea, which was almost covered with numerous spots of the so-called *keratitis punctata*. It was noteworthy that all this had occurred with only a slight amount of pain and discomfort, and that the patient was a delicate girl of the "strumous" type. The treatment advised was removal to the sea-side, the use of maltine, and of grey powder in $2\frac{1}{2}$ grain doses every night. Atropine had been instilled into the eye and fomentations applied. Under these conditions the state of the eye and the patient's general health had both improved. A third patient showed the early and acute stage of cyclitis; and in a fourth patient an example of syphilitic iritis was exhibited.

Speaking on the subject of cyclitis, Mr. Clarke pointed out the great amount of damage this disease was capable of inflicting on the eyeball. This may be due, in the first place, to the non-absorption of the inflammatory products, and, secondly, to the cicatricial contraction of these. As a result of the latter process, detachment of the retina may be produced, as was illustrated by a number of sections shown to the class.

Wound of the Eyeball.

This case was a good example of conservative surgery applied to the eyeball. There had been originally a penetrating wound of the sclerotic with escape of vitreous—a condition which, a few years ago, would have been met by enucleation of the eyeball. But in the present case, after cleansing the parts, the protruding vitreous had been cut off, and the wound in the sclerotic closed by catgut sutures. This had taken place five weeks ago, and now all that is to be seen is a small pigmented scar. Vision in the injured eye has improved to the level of $\frac{6}{12}$. It was pointed out that one of the risks of such an injury is detachment of the retina, but this fortunately had not occurred in the present instance.

DISEASES OF THE SKIN.

BY J. M. H. MACLEOD, M.D., M.R.C.P.

*Monday, June 23, 1902.**A Case of Iodic Acne.*

THE patient was a young woman who had taken a mixture containing iodide of potassium for three weeks. The exact dose of the drug taken was not ascertained. About a week after she began to take the drug, indolent acneiform lesions appeared on the face, and several of these became enlarged and formed granulomatous masses almost as large as filbert nuts. On puncturing the lesions very little pus could be expressed, but a quantity of a limpid, blood-stained, serous fluid oozed out. The lesions were dark red or purplish in colour, and were most marked on the chin, cheeks, and forehead, the usual sites where the lesions of acne vulgaris occur. When she came under treatment at Charing Cross Hospital the iodide mixture was stopped, and with the aid of local antiseptic treatment and incisions to let out pus, the condition of the face has gradually improved, and it is hoped that the granulomatous masses will completely disappear without leaving any marked scarring.

A Case of Hypertrophic Lichen Planus.

The patient, a middle-aged woman, had suffered from lichen planus off and on during the last five years. She was a healthy-looking woman, with a markedly neurotic temperament. At the present time the lesions are chiefly confined to the fronts of both knees, and consist of a number of small typical papules of lichen planus, by the coalescence of which several raised plaques have been formed. The latter presents a lilac tinge, with a rough, whitish surface resembling shark's skin. Associated with the lesions are considerable irritation and itching. The patient is, however, able to bear the application of strong remedies, such as salicylic acid, to the lesions, and it is found that only these have any decidedly beneficial action on the disease. There are several whitish striæ

in the buccal mucosa opposite the lower wisdom tooth, which is a situation in the mouth where lesions of lichen planus usually form.

A Case of "Linear Papillomata."

The patient was a young girl on the backs of whose hands and forearms there were numerous small lesions resembling small, flat warts, which had a marked tendency to be arranged in rows. They appeared for the first time a year ago. They did not correspond in their distribution to that of cutaneous nerves, Voigt's lines, or blood-vessels.

A Case of Rodent Ulcer treated by the X-rays.

The patient, a man, aged 42, had a rodent ulcer situated on the left pinna and extending for about half an inch on to the skin of the cheek in front of the tragus. Four years ago a small rodent ulcer had been excised from this situation. Eighteen months ago the scar began to break down, and at the present time a rodent ulcer has again developed with a typical rolled cartilaginous edge. The patient has been under treatment with the Röntgen rays during the last six weeks. He has had four exposures, each of fifteen minutes' duration and at a distance of six inches from a soft tube with a 10-inch spark. A reaction occurred a few days after each exposure. The edge has broken down and flattened, and the ulceration in the centre looks healthier, and, though the ulcer cannot as yet be claimed to be cured, there is a marked improvement, and the possibility of still further benefiting the patient by another cycle of exposures is entertained. It is a case which is peculiarly suited for treatment by the X-rays, as the lesion is an unusually superficial one owing to its being chiefly confined to the concha of the ear.

A Case of Deep Pigmentation Produced by Repeated Exposure to the X-rays.

The patient, a middle-aged woman, had been under treatment with the X-rays for a patch of lupus situated on the neck. She had had exposures twice a week for fifteen months, and during the exposures the rest of the face was not protected in any way from the action of

the rays. Surrounding, but not involving, the lupus patch a zone of deep pigmentation had been produced, giving the affected skin an appearance like that of the skin of a mulatto. The rays had also produced a dermatitis and caused a falling out of the hair. Since coming under observation at Charing Cross Hospital the pigmentation has begun to diminish and the hair to grow again without any treatment.

A Series of Six Cases of Lupus Vulgaris.

These were exhibited with the object of demonstrating the beneficial effect of the Finsen rays in the treatment of lupus. In two of the cases a thoroughly satisfactory result had been obtained; the others had greatly improved, but were still under treatment. A case of lupus vulgaris in a young woman, which had been treated by scarification, and repeated applications of the actual cautery, was also shown. The disease has now been treated for six months, and to all appearances has been completely cured, and the scar—about $1\frac{1}{2}$ by $\frac{1}{2}$ inch—is slightly depressed, but has the same colour as the surrounding skin, and is very slightly noticeable.

DISEASES OF THE NOSE, THROAT, AND EAR.

BY HERBERT TILLEY, M.D., F.R.C.S.

The Treatment of Atrophic Rhinitis.

THE patient, a girl of 13 years, had for some months been under treatment, mainly by various local remedies applied to the interior of the nose in the form of sprays. This method Dr. Herbert Tilley described as quite inadequate. It is insufficient to remove the closely adhering crusts which are the most prominent feature of the disease. To effect the removal of the crusts, it is essential that a forcible stream of fluid be driven into the nose by means of a Higginson's or similar syringe. The nature of the fluid is of less importance than the mechanical method of its application. If gently carried out there will be little risk of setting up acute

inflammation of the ear. A solution of 1 drachm of common salt in a pint of water used twice daily is often successful and has the advantage of cheapness. Another useful formula is obtained by adding 1 drachm of a 50 per cent. solution of aceto-tartrate of aluminium to a pint of water. But neither these nor any other prescription will avail unless thoroughly and energetically used. Apart from syringing, the formation of crusts may be retarded by packing the nasal cavities with strips of lint soaked in glycerine. The lint is left in position for some two or three hours. It causes a free secretion from the mucous membrane, which tends after repeated applications to make it much healthier. On removal of the packing the nostrils must be freely douched with a warm alkaline lotion. Whichever of the above methods be adopted, the next indication is to prevent further formation of crusts. This may be accomplished by spraying the nasal cavities with a solution of a volatile oil in paroline, using for choice some form of atomizer. A suitable prescription is oil of eucalyptus and oil of cinnamon, of each 5 mins., menthol, 10 grains, paroline to 1 ounce. In addition, the patients usually need a prolonged course of cod-liver oil, syrup of iodide of iron, or other tonics. A complete cure can hardly be hoped for, but much may be done to minimise the symptoms and to check the progress of the disease.

A Case of Epithelioma of the Soft Palate.

The patient was a man of 61 years. He complained of pain in swallowing, the pain extending into the neighbourhood of the left ear. On the left half of the soft palate and uvula was a well-defined ulcer with a prominent edge and a grayish papillary surface. Dr. Tilley discussed the diagnosis as between epithelioma and syphilis, and concluded that the characters of the ulcer were decidedly those of malignant disease. In speaking on this point he said that improvement under potassium iodide was no guarantee of the syphilitic nature of such an ulcer, as a similar, though temporary, improvement often takes place in malignant growths. As the disease was limited to the curtain of the palate and did not extend along the faucial pillars to the lateral walls of the pharynx, and as, further, there was no evidence of glandular enlargement, Dr. Tilley advised

complete removal of the soft palate. Such an operation would necessarily produce a "nasal voice," and it is advisable to warn the patient of this beforehand.

Other cases were (1) a man, aged 61 years, with abductor paralysis of the left vocal cord; (2) a boy with adenoid growths in the naso-pharynx; (3) a young woman with perforation of Shrapnell's membrane and destruction by caries of the head of the malleus.

BY RICHARD LAKE, F.R.C.S.

Sclerotic Changes in the Middle Ear.

A WOMAN of about 30 years attended complaining of deafness on the right side. Examination of the ear showed an extremely interesting condition, and Mr. Lake expressed his satisfaction at such an interesting case being brought forward.

The anterior half of the membrana tympani was calcareous, whilst the remainder was extremely attenuated and presented the appearance of a bleb; at its upper part was a small depression. The calcareous portion probably dated from early life, though it might have been due to later sclerotic changes, whilst the other half, becoming atrophic, had been distended by the patient's attempts to inflate her ear with a view to obtain better hearing.

The treatment suggested was to attempt to reduce the obstruction due to hypertrophic rhinitis, together with the removal of an enlarged posterior end of the inferior turbinate, and, later, occasional gentle inflation of the ear, the performance of Valsalva's inflation being prohibited. The posterior half of the tympanic membrane was ordered to be painted with collodion.

The Radical Mastoid Operation.

A case was shown in which a complete mastoid operation had been performed and cure obtained, but the patient had again presented herself at hospital complaining of pain around the ear, the cause of which had not been determined. On questioning the patient it was found that all pain had now ceased. There was

no tenderness in the surrounding tissues as there had been at the previous examination, but there was an acute eczema of an impetiginous character on the posterior aspect of the pinna. This was probably of herpetic origin and accounted for the previous pain. The application of zinc ointment was recommended.

Hypertrophy of the Lingual Tonsil.

A patient was shown with an enlargement of the lingual tonsil. She complained of a sensation as of a foreign body in the throat; she had also had naso-pharyngeal catarrh. The enlarged lingual tonsil had been cauterised, and this had given much relief, but the treatment which was producing greatest benefit was that directed to the cure of the naso-pharyngeal trouble. This consisted, besides the administration of small doses of quinine internally, in the local application on a cotton wool mop of Mandl's solution, with the use of a nasal wash.

The other symptoms of enlargement of the lingual tonsil were referred to, and Mr. Lake expressed his belief that if the original description of enlargement of the lingual tonsil had not been included in a description of enlarged veins, no one would have found fault with the symptoms attributed to it.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. JONATHAN HUTCHINSON.

(Continued from page 447.)

Coxa Vara in a Young Man (Dr. Stocker's Patient.)

WE have had under observation from time to time several examples of that peculiar condition of loss of the obliquity of the neck of the femur and consequent shortening of the affected limb, to which the name Coxa Vara has, of late years, been applied. A most instructively typical one occurred in a young man who was

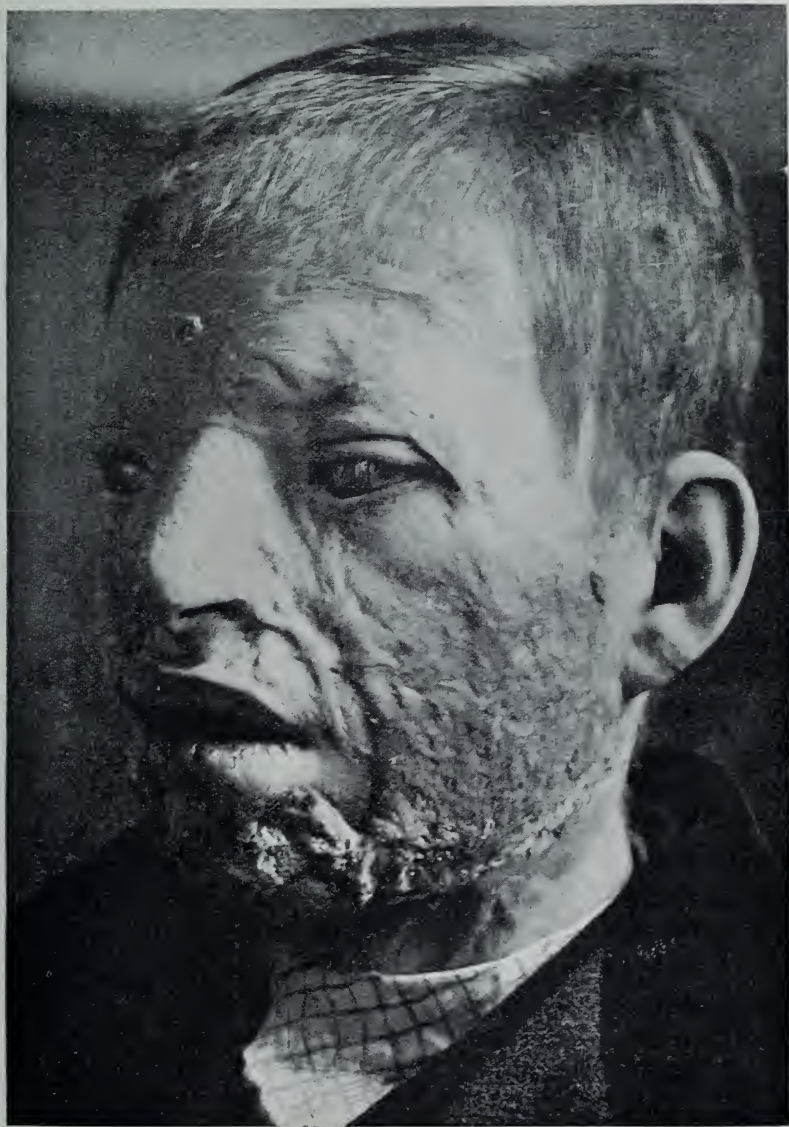
sent to us by Dr. Stocker, of Forest Gate, and in whom we had opportunities for watching the progress of the disease through its stages. Although long before the term "Coxa vara" was devised I had been well aware that under certain conditions the neck of the femur might be shortened or almost lost, there were certainly some features in this young man's case which were new to me, and which I observed with the greatest interest. Briefly, I may say that without any injury the lad became lame on the right side, and after continuing to go about with a limp for some weeks, he was made to rest at home. There was at this stage some little pain about the hip, and disease of the joint was suspected, but the symptoms were never severe enough to make him keep his bed, and when after a six months' rest he was sent to us, he travelled up from Forest Gate and was able to walk freely. We found him with free movement at the hip joint, but with a limb an inch or more shorter than the other and a little everted. During the next few months he lost all pain and became able, with a high-heeled boot, to walk almost as well as ever. It is now two years since the beginning of his symptoms, and we have seen him recently and have found him quite recovered. During the last year he has been pursuing his vocation as a clerk in the City without inconvenience. Now the revelation which was made to me by this case was that it is possible for a local process of osteitis, independently of injury and without acute symptoms, to soften the neck of the femur so as to permit of an alteration in its form, and then for consolidation to ensue, the patient remaining throughout, apparently, in good health. In most of the cases which I had previously seen, the patient had been subjected to some violence, so that displacement of the epiphysis might be suspected, or the symptoms had been more severe. In this instance we had no proof of either rickets or scrofula, nor was there any history of rheumatism. It is important to note, however, that the patient's age would permit of there being still some remains of the epiphysal cartilage unossified, and in this structure, not improbably, the changes had been initiated.

Difficulties in the Diagnosis of Keloid of Scars.

A case of some interest in reference both to diagnosis and probable causation came before us in the person of a comely German

woman, aged about 30. Two long streaks of keloid extended with almost accurate symmetry obliquely across her shoulders. They were nearly nine inches long, but nowhere more than about an inch in width. The extremities of each showed the raised, thick, and somewhat glossy border characteristic of aggressive keloid, but in both the middle part of the band had softened down, become pale, and looked like an ordinary scar. We were told that the case had elsewhere been confidently diagnosed as morphœa (sclerodermia), the shape of the bands, their obliquity, bi-lateral symmetry, and the pale, scar-like condition of their central parts having been thought to imply that malady. I ventured to insist that there could be no question as to their real nature and that the state presented by their still advancing extremities was quite pathognomic. In morphœa, when once established, the margins never advance, nor are they ever raised and glossy, the middle of the patch being usually the thickest. In this case we had, besides, the patient's history. She told us that she had had the patches from childhood, and that they were still spreading. Excepting that they itched intolerably, they had caused no inconvenience. She denied, it is true, that there had ever been any wound or other injury, and held that the patches had come of themselves. Mr. Hitchens, who was present, made a suggestion which helped us in this matter. He pointed out that the keloid bars were exactly in the positions on which the child's bare shoulders might have been struck repeatedly in the course of school discipline. The woman subsequently showed us another similar streak which crossed one buttock in a position strongly confirmatory of this hypothesis. Adopting Mr. Hitchens' suggestion as to cause as being probably the correct one, I show the photograph of a soldier over whose shoulders numerous lines of cicatricial keloid had formed, as the result, it was believed, of severe flogging.

As regards treatment I strongly advised that no operation should be done, pointing out that the keloid growth would be certain to return in the scar. In connection with this assertion I mentioned a number of cases which had come under my own observation, and also adduced a photograph recently added to our museum collection by the kindness of Dr. Hall, of Sheffield. In Dr. Hall's case a boy had been burnt on the face with sulphuric acid; keloid had resulted, and treatment by excision of a part had been speedily followed by recurrence.



*Keloid in the scar of a burn from sulphuric acid.
From a photograph by Dr. Hall, of Sheffield.*

GIANTS AND ACROMEGALY.

Our pages have repeatedly contained references to recent theories of Acromegaly and Giantism. The following which we quote from the *Times* report of the British Association will interest many of our readers :—

PROFESSOR D. J. CUNNINGHAM, F.R.S., then read an interesting paper on “Cornelius Magrath, the Irish Giant,” whose skeleton was exhibited by permission of Trinity College, Dublin, of which it has been a treasured possession for nearly a century. His great stature, Professor Cunningham observed, was referred to in most works on anthropology, his real height having been 7ft. 5in. He was born in Tipperary in 1736, and was exhibited in all the principal cities of Europe as a giant. He died in 1760, in Dublin, when his skeleton was obtained by Trinity College. Professor Cunningham described what was, in all probability, his personal appearance during life, and the picture he drew was not flattering to Magrath, he being nearly blind, knock-kneed, and having a very decrepit look. The skeleton was important, in the reader's opinion, from an anthropological point of view in respect of the question of acromegaly. His conclusion was to the effect that giantism was a morbid process closely allied to the disease known as acromegaly, in which the face, hands, and feet became enlarged. In giants there was also an enlargement of the face and a more or less uniformly excessive growth of the limbs. He supported the view, advocated by Dr. Woods Hutchinson, that giantism and acromegaly were virtually the same morbid process differing according to the time at which the disease made its appearance. If the individual was attacked in early youth before the skeleton was consolidated a giant was produced; if after 26 years of age, when the skeleton was consolidated, acromegaly resulted.

PROFESSOR A. F. DIXON then exhibited a skull modified by acromegaly, and observed that it showed an extraordinarily large face associated with hypertrophy of the pituitary body, and that up to the present no satisfactory explanation had been given as to why a pathologically enlarged pituitary body should be associated with an enormous development of the face. These acromegalic people were of the greatest interest from an anthropological point of view, as we had now much evidence to show that, in spite of the grandiose tales handed down by folklore, nearly half the number of people afflicted with giantism had been subjects of this disease, acromegaly. That too much reliance should not be placed upon the tales told in folklore of the prodigious strength and powers of giants could be inferred from Professor Cunningham's account of Magrath, of whom it was said in an account, published during his life, that he was “the only representation in the world of the ancient and magnificent giants” of Ireland, and “the truest and best proportioned figure ever seen.” Cases of acromegaly had occurred before Magrath. It had already been suggested that the photographs of Hen Neck, the giant King of Egypt, who lived about 4,000 B.C., showed appearances not incompatible with the idea that the individual was an acromegalic. It had been suggested that giantism and acromegaly were expressions of the same, or at least, similar, disturbances of nutrition. It would appear that, if the disease began before adult life was reached, it might lead to the limb bones continuing to grow

for a longer time or at a greater rate, and hence to giantism. On the other hand, there was evidence to show that, if it was acquired in later life after the limb bones had ceased growing, it was not associated with abnormal height in the individual.

LEPROSY IN INDIA. NOTICE OF MEETING.

IN connection with the National Leprosy Fund (of which H.M. the King, when Prince of Wales, was President), a Meeting will be held in the large room of the Polyclinic, on Wednesday, November 26. All who incline to attend, whether members of the Polyclinic or not, are invited. The subject of the "*Present State of the Leprosy Question in India*," will be introduced by Mr. Hutchinson, who is about to leave home for a tour of investigation in Ceylon and India. The chief object of the Meeting is to collect from medical men, missionaries and others who have lived in India, statements of their experience. It is hoped that these statements will, as far as possible, relate to facts that can be substantiated, and that mere expressions of opinion will be avoided. Sir Joseph Fayrer, K.C.B.I., will take the chair, and it is understood that the greater part of the time will be devoted to open discussion. The meeting will commence at 2.30 o'clock, but the models, maps, &c., will be open for inspection at 2.

CORRESPONDENCE AND ANSWERS.

To the Editor of the POLYCLINIC.

"The Warren, Caversham, Reading.

"August 16, 1902.

"DEAR SIR,

"I am no longer in practice, but, seeing you are seeking information about cancer, send you the following:—Mother died of cancer of breast; father died of cancer of jaw; eldest daughter died of cancer of breast; second daughter died of cancer of breast. Only son left home for South Africa early in life, still living, aged 78. No other children. I looked on this as heredity—is it not contagious?

"Yours very truly,

"GEORGE MAY."

SIR BENJAMIN RICHARDSON ON OPERATIVE SKILL.—“Mr. de la Garde of Exeter was, before the days of anæsthesia, so brilliant an operator that people went to him from all parts of England in order that he might use the knife, or knife and saw, on their bodies. William Cheselden, the eminent surgeon, seems to have been possessed of the same quality so strongly that one of his patients sang of him—

‘So swift thy hand, I could not feel
The progress of the cutting steel’

and Dr. Willis told me that his friend Liston was an operator of the same type, one who could amputate the thigh in twenty-five seconds, so that there really was little time for agony.”—*Vita Medica*, by Sir Benjamin Ward Richardson.

* * *

YAWS CURED BY MERCURY.—To those who believe that syphilis and yaws are the same malady and that mercury is the specific for both, the following quotation from a report by Mr. W. D. Wright, Government Agent in 1871 for the North-Western Provinces of India, will be of interest. Mr. Wright was not a medical man. He states that it is customary in remote parts of the various districts to infect their children with Yaws when a year old. “In a short time pustules . . . appear on the child’s body, and then medicines containing minute quantities of mercury are administered, which cause the pustules to dry up . . . the scales to fall off, leaving deep dark marks which in course of time disappear. It is said that this is an almost certain prophylactic, and that though the disease may attack one who has been so guarded the effects are never serious.”

Here we seem to have the early treatment, by mercury, of a syphilitic eruption (under the name of yaws) represented as very successful and as preventive of any serious subsequent ill-effects. Yaws occurring in infancy and cured by mercury was held to be preferable to yaws allowed to run its course.

* * *

PARASITES, such as those seen on the leaves of the birch and the maple, are injurious to the trees infested only when abundant. They interfere with the assimilation, or digestive functions, of the leaves. Thus the elaboration of sap is defective.

They are in all respects analogous to the cryptogamic diseases of the human skin. If only limited in extent they do but little harm to the general health of their host, but in proportion to their extent they interfere with functions. Ring-worm in children is rarely sufficiently extensive to materially affect the functions of the skin and thus interfere with the health. Favus, on the other hand, may in rare cases cover almost the whole body and it becomes then very prejudicial to health. Cases in which it was materially contributory to a fatal issue are on record.

* * *

IN “Kelly’s Geography” it is asserted that the Hottentots never eat salt, although it is plentiful.

* * *

S. W. Y. M. writes:—The importance of putting the adverb in its proper position in the sentence is well shown in the following:—“He was a wine merchant, and though he had never drunk to excess, he had frequently taken

small quantities in the way of business." What Mr. B. meant to convey was, probably, that his patient "had, in the way of business, taken small quantities frequently."

* * *

Re CANCER AND ARSENIC.

To the Editor of the Polyclinic.

" 530, Commercial-road-east, Stepney.

" October 22, 1902.

" Dear Sir,

" Has not, up to the present, a large class of cases been overlooked in connection with this subject—the epileptics. Is not here arsenic taken over a great number of years? Would it not be helpful to know whether these patients are more subject to cancer than others.

" Yours truly,

" HORACE RICHARDSON."

* * *

PRESIDENT ROOSEVELT ON LEPROSY.—For the following extract we are indebted to Dr. Bridger, of Portland-place. At page 85, "Trail and Camp Fire," by G. B. Grinnell and Theo Roosevelt (now President, U.S.A.), published by David Douglas, Edinburgh, 1898, occurs the following:—"The fact that these natives do not eat fish would tend to substantiate the medical theory, that fish-eating is a pre-disposing cause of leprosy. All along this part of the coast," *i.e.*, of East Africa near Somaliland and Abyssinia, "no leprosy is apparent, whereas at Lamu, further south, where fish is a regular article of diet with the natives, there is a considerable leper population."

* * *

EXTINCTION OF LEPROSY BY CHANGE OF PLACE OF RESIDENCE.—THE following is an extract from a short but able letter from Dr. Thomas Wright Hall, of Bahia, which appeared in the Journal of the Leprosy Investigation Committee in 1891 (see page 107).

"I myself know of a case in which leprous families of negro slaves were exiled deep into the fertile woods of Northern Brazil. In their exile they were furnished with means of rearing poultry, pigs, goats, of fishing, trapping game, of cultivating cassava, yams, plaintain, maize, &c., and then they were left entirely to themselves. Among these exiles, when visited after the lapse of many years, leprosy was found extinguished; a sound negro colony occupied the place of the old leprous one."

[This statement of fact is quoted by Dr. Thin in his work on Leprosy as if it favoured the theory of contagion and the practice of isolation. Clearly it does nothing of the sort. Whole families, some of their members being diseased and some healthy, were sent away inland in order to protect the community which remained behind. We are not told whether the measure was successful as regards that community or not, but we are told that when the infected families were removed from where the disease had originated they got rid of it.—Ed.]

MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

SCHEDULE OF CLINQUES AND LECTURES

From **SEPTEMBER** to **DECEMBER**, 1902.

Cliniques at 4 p.m.

MONDAYS. (<i>Skin</i>)	TUESDAYS. (<i>Medical</i>)	WEDNESDAYS. (<i>Surgical</i>)	THURSDAYS. (<i>Surgical</i>)	FRIDAYS. (<i>Eye, Ear, Nose, and Throat</i>)
Sept. 8 College opens	Sept. 9 Dr. James Taylor	Sept. 10 Mr. P. J. Freyer	Sept. 11 Mr. Hutchinson	Sept. 12 Dr. Jobson Horne
Sept. 15 Dr. J. Galloway	Sept. 16 Dr. C. O. Hawthorne	Sept. 17 Mr. Reg. Harrison	Sept. 18 Mr. Hutchinson	Sept. 19 Mr. R. Lake
Sept. 22 Dr. A. Whitfield	Sept. 23 Dr. J. E. Squire	Sept. 24 Mr. Jackson Clarke	Sept. 25 Mr. Hutchinson	Sept. 26 Dr. Herbert Tilley
Sept. 29 Dr. Graham Little	Sept. 30 Dr. Harry Campbell	Oct. 1 Mr. James Berry	Oct. 2 Mr. Hutchinson	Oct. 3 Mr. Ernest Clarke
Oct. 6 Dr. J. F. Payne	Oct. 7 Sir Wm. Broadbent	Oct. 8 Mr. J. Cantlie	Oct. 9 Mr. Hutchinson	Oct. 10 Dr. Dundas Grant
Oct. 13 Dr. J. Galloway	Oct. 14 Dr. Seymour Taylor	Oct. 15 Mr. Reg. Harrison	Oct. 16 Mr. Hutchinson	Oct. 17 Dr. St. Clair Thomson
Oct. 20 Dr. A. Whitfield	Oct. 21 Dr. W. Ewart	Oct. 22 Mr. F. C. Wallis	Oct. 23 Mr. Hutchinson	Oct. 24 Mr. Work Dodd
Oct. 27 Dr. J. M. H. MacLeod	Oct. 28 Dr. Theo. Williams	Oct. 29 Mr. J. Berry	Oct. 30 Mr. Hutchinson	Oct. 31 Mr. P. R. W. De Santi
Nov. 3 Dr. J. F. Payne	Nov. 4 Dr. James Taylor	Nov. 5 Mr. J. Hutchinson, Junr.	Nov. 6 Mr. Hutchinson	Nov. 7 Dr. Herbert Tilley
Nov. 10 Dr. Graham Little	Nov. 11 Dr. Guthrie Rankin	Nov. 12 Mr. Jackson Clarke	Nov. 13 Mr. Hutchinson	Nov. 14 Mr. Marcus Gunn
Nov. 17 Dr. Colcott Fox	Nov. 18 Sir Wm. Broadbent	Nov. 19 Mr. J. Hutchinson, Junr.	Nov. 20 Mr. Hutchinson	Nov. 21 Dr. Dundas Grant
Nov. 24 Dr. J. T. Pringle	Nov. 25 Dr. Seymour Taylor	Nov. 26 Mr. A. H. Tubby	Nov. 27 Mr. Hutchinson	Nov. 28 Dr. St. Clair Thomson
Dec. 1 Dr. J. F. Payne	Dec. 2 Dr. W. Ewart	Dec. 3 Mr. E. W. Roughton	Dec. 4 Mr. Hutchinson	Dec. 5 Mr. Tracher Collins
Dec. 8 Dr. J. Galloway	Dec. 9 Dr. Theo. Williams	Dec. 10 Mr. A. H. Tubby	Dec. 11 Mr. Hutchinson	Dec. 12 Mr. R. Lake
Dec. 15 Dr. J. M. H. MacLeod	Dec. 16 Dr. R. L. Bowles	Dec. 17 Mr. J. Cantlie	Dec. 18 Mr. Hutchinson	Dec. 19 College closes.

Clinical Lectures at 5.15 p.m.

Oct. 15th.—Gilbert Barling, Esq., F.R.C.S., Birmingham.

Oct. 29th.—P. H. Pye-Smith, Esq., M.D., F.R.C.P.

Nov. 12th.—Judson S. Bury, Esq., M.D., F.R.C.P., Manchester.

Nov. 19th.—Peter Horrocks, Esq., M.D., F.R.C.P.

Nov. 26th.—Allan Macfadyen, Esq., M.D., B.Sc.

Dec. 10th.—H. E. Juler, Esq., F.R.C.S.

Special Courses of Lectures at 5.15 p.m.

Oct. 3rd, 10th, and 17th.—Mr. Bellamy Gardner, "The Administration of Anæsthetics" (with practical demonstrations).

Oct. 6th, 13th, and 20th.—Dr. G. E. Herman, "Pelvic Inflammations."

Nov. 3rd, 10th, and 17th.—Dr. W. S. Colman, "Infant Feeding, and Ailments due to unsuitable Feeding."

Nov. 7th, 14th, and 21st.—Dr. Louis Sambon, "Parasitism in Man."

Nov. 28th, Dec. 5th, and 12th.—Dr. S. E. Dore, "The Therapeutic Uses of the Röntgen and Finzen Rays" (illustrated by Cases).

Dec. 1st, 8th, and 15th.—Dr. Harry Campbell, "Respiratory Exercises and Thoracic Dynamics."

A. E. HAYWARD PINCH, F.R.C.S., Medical Superintendent

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. VI., No. 12.—DECEMBER, 1902.

RETROSPECTIVE.

As the present is the last number of our Journal which will be issued during the current year, we may be permitted, although a little prematurely, to attempt a retrospect. It has been, we trust, a year of steadily increasing usefulness in all departments of our work. Our list of subscribers has gone on increasing and now numbers not much short of a thousand, and our clinical demonstrations and lectures have been attended by larger numbers than ever before. It would be invidious and, indeed, where the number is so large, impracticable to name those to whom we have been chiefly indebted, but we may fairly claim that a large proportion of the foremost clinical teachers, not only of the metropolis, but of the sister kingdoms and the provinces, have given us their help. These statements apply to our afternoon lectures and demonstrations, and respecting the latter it may be added that the attendance of cases of importance has been good, and that as regards instruction both in diagnosis and treatment, the opportunities afforded have been very valuable. Many cases of almost unique interest have been presented in our consultation theatre.

It is needless to remind our subscribers that the purview of the Polyclinic is world-wide, and that we desire to study and elucidate the phenomena of disease, not solely as regards the British Isles, but with reference to the whole British Empire. In the attempt to discharge the high function to which we aspire, our work has divided itself into several different parts. In the first place it has been our duty to consider the interest of the patients who have been brought to us for consultation; in the next that of those who have come to us in the wish to perfect their clinical knowledge; and in the last the advancement of medical science in its widest sense. Thus our three-fold aim may be said to have been original investigation, clinical teaching, and the giving of advice. Nor have we found these objects incompatible. Whilst making out our diagnosis, we have also been able to afford clinical instruction, and not infrequently to secure new observations as to the nature of various forms of disease. These have found permanent record in our Journal, and have often afforded material for further examination by one or other of our standing committees. We may claim that we have kept close to our work, and have resisted all temptations to divergence. Our Journal has made no attempt to compete with its contemporaries as a vehicle for medical news, or a periscope of contemporary literature. We have not meddled with medical politics, nor, with the very rarest exceptions, have we alluded to any topic not of purely clinical interest. Our self-restraint in these matters may possibly have incurred some loss of popularity, but it has, we believe, served well the main purpose for which the Polyclinic exists—the increase and the diffusion of a sound knowledge of disease.

LEPROSY.

It may have seemed to some of our home subscribers that the subject of leprosy has occupied an undue share of our pages. But, in truth, this is really one of the most important of the medical questions of the day, and it is one, if we mistake not, which is ripening for a satisfactory solution. Not only does it directly concern the happiness of a very large number of British subjects, but it presents clinical and pathological problems of the very foremost interest. Too long has the medical profession been content to maintain a position

of lukewarm and desultory interest in it. It is high time that the attention of the profession was claimed as a duty to mankind, and medical responsibility strongly urged. The scope of our own work in respect to it has been three-fold. Patients suffering from the disease have been repeatedly produced in our consultation theatre, and no effort has been spared on these occasions not only to elucidate its symptoms and course, but to trace in each instance its probable cause, and opportunities for discussion have been freely offered. Our Standing Committee on Leprosy, of which Dr. Radcliffe Crocker is the chairman, has met several times. It is an open committee, at which all are welcome, and which invites from all the expression of opinions and the citation of facts. One of the most interesting events of the year was a meeting of this committee at which Dr. Hansen attended, and which resulted in much enlightenment to many. The references to leprosy which have occurred in our Journal have been in part based upon what has been brought before this committee, and in part upon published statements in Government reports. From the oblivion of the latter we have recently rescued most important statements respecting the population of Minicoy, and have taken occasion to urge that a month's zealous investigation on that island might not improbably set at rest the leprosy problem. If it has seemed to any of our readers that the personal opinions of the editor have received undue support from the facts and explanations which have been quoted, it may be fairly replied that this has been unavoidable.

CANCER.

The subject of cancer has received much attention during the past year. The absolute necessity for prompt diagnosis and immediate operation in all suitable cases has been urged unceasingly in our lecture theatre and in the pages of our Journal. It has been recognised by those taking part in our surgical consultations that amongst the most valuable of the lessons which can be there taught are those which concern the early diagnosis of cancer, and the abundant opportunities which occurred for enforcing them have, we believe, been well utilised. Occasions have also occurred for

calling attention to the fact that the hope of prolonged life, and even of permanent cure, by the operative treatment of cancer, if undertaken early, is far better than is generally supposed.¹

The fact that, in spite of the triumphs of modern surgery, the ratio of death from cancer, as revealed by statistics, is steadily on the increase, has also claimed our attention. It has been the subject of debate in our Standing Committee on Cancer, and from what transpired at that committee one very important item of advance in knowledge has accrued. It was then suggested by Dr. Solomon Smith that probably the cancer of chimney-sweeps was caused by the presence of arsenic in soot. It needed but to have this suggestion made for its value to be recognised. We at once pointed out that Sir James Paget's classical description of the state of the skin in chimney-sweeps was precisely that which occurs in chronic arsenical poisoning, and that, in common with other observers, Sir James had avowed his inability to explain the connection between soot and cancer. Putting these and certain other facts together, the truth became evident, and we may now fairly claim that soot-cancer has been proved to be caused by the arsenic which abounds in certain kinds of soot. The question as to whether arsenic is responsible for any large share in the recent increase of cancer is one of great intricacy. That it produces a certain number of cases is beyond doubt, and the question is how many. It may be that the number is very large, or it may be that it is very small; future investigation must decide. We have endeavoured, both in the committee and in our Journal, to state as clearly as may be such facts as are available, and have, side by side with them, asked attention to other factors, that of generally increased longevity being the chief, which have probably conduced to the result. Our museum possesses the best collection (perhaps the only one) of portraits illustrating the cancer of arsenic which exists, and our members have in our Extract Book access to a large collection of evidence. If what has been adduced should lead, not to the disuse, but to the more cautious employment of arsenic during long periods of time, a very important gain will have accrued.

¹ The instructive lecture given by Dr. Lewers a few weeks ago on the treatment of cancer of the uterus was not the least important contribution to this question.

YAWS.

Our Standing Committee on Yaws has not met during the year, for the good reason that there has been nothing to be submitted to it. Its meeting in November, 1901, at which Dr. Finucane stated his experience in Fiji, and Dr. Collingwood his in Ceylon and other places, may be considered to have decided the question in dispute. There will probably be no further serious dispute that yaws, parangi, &c., are identical with syphilis, and depend upon race and climate for their supposed peculiarities.¹ This committee may now be dissolved, and it will probably not be needful to occupy our pages with many more allusions to it.

TUBERCULOSIS.

Not much special work in reference to tuberculosis has been done by our committee during the year. This subject has the advantage of being very prominently before the profession, and of receiving the constant attention of very able investigators. In these respects it stands in strong contrast with such subjects as leprosy and yaws. We may boast that our museum contains an unrivalled collection of portraits illustrating all forms of tuberculous disease of the skin, and during the year these have been, to some extent, rearranged and catalogued. In our consultation theatres, also, not only have the subjects of pulmonary disease been very frequently produced for clinical comment and diagnosis, but very instructive examples of the more exceptional forms of external scrofula—as of the skin, glands, joints, bones, &c.—have repeatedly come under notice.

THE MUSEUM AND LIBRARY.

Large additions have been made both to our library and museum. In the latter a great deal of labour has been expended in the arrangement and indexing of the drawings which are not displayed on our walls. Under the supervision of the Conservator this has been effected by the diligence of Mr. E. W. Swanton and Dr. Saleeby.

¹ A fasciculus, published by the New Sydenham Society, illustrating these affections, gives a detailed summary of the facts. It may, however, be fairly claimed for the Polyclinic that the real work was done in its committee room.

This collection (in portfolios) is a very large one, and it is now so classified and indexed that any lecturer or other enquirer can, at a few minutes' notice, obtain whatever he may be in search of. The close proximity of the collection of portraits in our museum to our lecture theatres constitutes one of our strong points in reference to clinical teaching.

THE CLINICAL LABORATORY AND TEACHING CLASSES.

The Clinical Laboratory has been in active work throughout the year. Many analyses have been made, and Captain Pinch's pathological class has always been crowded. We cannot say quite so much as to the special teaching classes, in which we could desire a larger attendance. It is a satisfaction, however, to know that it has been better than in former years, and shows a tendency to steady improvement.

RE-ARRANGEMENT OF FEES.

As foreshadowed in our last issue the Council has had under its consideration certain modifications in the fees payable by those who avail themselves of the various advantages offered by our College. The absolute necessity of providing an income which shall balance the expenditure has been one reason for the readjustments which have been decided upon. This need, although paramount, has not been the only motive for the changes. Apart from the generally recognised fact that an annual payment of a single guinea is almost ridiculously low, it has long been felt that there was a failure of due adjustment to the very different utilisation of the privileges offered by different groups of our subscribers. To these privileges a very large addition has been just made by the institution of a course of systematic lectures. These lectures have during the past three months been given without additional fee. The first and most important change which has been decided upon is to require a guinea fee for this course, and to merge with it the "Clinical Lectures and

Short Special Courses" which have hitherto been free. As these lectures will be given every afternoon, five days a week, throughout the College year, and will be supported by the wholly gratuitous services of many of the foremost clinical teachers in the kingdom, no one can regard the fee as heavy. It is hoped that a large proportion of our subscribers will be able and willing to afford it. The only alternative would have been to increase the subscriber's fee to two guineas, and against this step there appeared the obvious objections that some subscribers might wish to continue as such, for the sake of the clinical demonstrations, who might not wish to take the lectures. It will be seen that under this arrangement our subscribers will lose the privilege which they have hitherto enjoyed of attending the systematic lectures without payment. They will, however, retain all their other privileges—the afternoon consultation clinics, the library and museum, and any extra lectures which may from time to time be arranged for. It is to be understood, however, that henceforth the hour from 5.15 to 6.15 will always be devoted to a lecture which will form part of the systematic course. Any other lectures (it is proposed to have a weekly "Museum lecture") must come earlier in the afternoon, that is before the four o'clock demonstration. Any such, we repeat, will be free. It will be seen that a very considerable addition to the work of the College, and to the opportunities which it affords, will be the result, whilst the additional charge to our subscribers will be trifling.

We come next to speak of those who desire to attend our classes, but who are not eligible as members. We have now on our books the names of more than nine hundred subscribers. Of these the majority are residents in or near London, and but few of these are able to attend our clinics with any regularity. They come when they can, they receive the Journal, and they send patients. Some subscribers are resident at great distance from London, or even abroad, and these subscribe in order to receive the Journal and to be able to look in when they chance to be in town. Another group, however, consists of those who are only temporarily resident in London, and are here for the express purpose of perfecting their medical training.

¹ These lectures have been called "clinical," but they have really been of precisely the same scope and character as those which will constitute the systematic course.

Many of these attend with great regularity for months together. It has long been felt that it was not just to treat in the matter of fees these different classes exactly alike, but it has been felt very difficult to effect adjustments which should not seem invidious. It has at length been decided to regard as eligible as subscribers those only who possess diplomas obtained in some part of H.M. dominions, and to charge an increased fee to all others, such being, presumably, in London only for clinical training, and likely to take the full value of their fees in regularity of attendance. They are, further, a class who are not able to assist the work of the College by sending interesting cases for demonstration, a department of usefulness in which many of our resident subscribers often put themselves to considerable trouble and some expense.

The adjusted scheme of fees is given below, and will in future appear regularly as an advertisement. The principles which have guided the Council in drawing it up we have endeavoured to explain, and they will, we trust, be found to be based on what is reasonable and right. Our fees are still, as they have always been, exceedingly low, and we have only to remind all concerned that they remain so, only because the band of teachers, many of them of world-wide reputation, give their services without any payment, and find their reward only in the knowledge that they are aiding the advancement of a profession which they love.

REVISED SCALE OF FEES.

The following scale of fees will come into operation on January 1, 1903:—All medical practitioners holding qualifications granted in any of H.M. dominions, wherever resident, are eligible as annual subscribers. To others tickets of admission are granted for stated periods.

The annual payment of a subscriber is due on January 1 of every year, and is ONE GUINEA. This entitles to (1) use of Library, Museum, and Reading Rooms; (2) attendance on Cliniques daily, at 4 p.m.; (3) receipt of Journal monthly, post free; (4) to bring or send patients for consultation; (5) to have specimens examined for small fees; (6) to attend the Museum Lectures; (7) to receive a ticket for the Daily Systematic Lectures on payment of an additional Guinea.

The fees for Special Classes (teaching classes) are extras, both to subscribers, and to those not eligible as such.

Fees to Non-Subscribers.

For those not eligible as subscribers the fees are as follows:—For the composite course of Lectures (daily) for the year or any part of the year (January to December) TWO GUINEAS.

Admission to Cliniques, the composite course of Lectures, the Library and Museum, and to receive the Journal monthly, post free:—Three months, £3 3s.; six months, £5 5s.; twelve months, £6 6s.

Admission to the privileges mentioned above, and also to single courses of any of the three Practical Classes:—Three months, £5 5s.

Admission to Cliniques and privileges mentioned above, and to all teaching classes given in the College:—Three months, £7 7s.; six months, £10 10s.; twelve months, £12 12s.

Subscription to the Journal.

The Journal will be sent post free to any address in the postal union, on prepayment of 10s. 6d. per annum, and anyone so subscribing will (if otherwise eligible) be allowed at any time to complete his position as a subscriber to the college, and obtain admission to the afternoon clinics, &c., on payment of an additional half-guinea.

A SPORADIC CASE OF LEPROSY.

Mr. ALEXANDER, of Liverpool, has recorded the case of a woman who came under his care at the Liverpool Workhouse Hospital and was known as the Swedish leper. "This woman had lived with her husband and six children without any signs of contagion being conveyed." She had never seen or known anybody with the same or a similar disease. Her father and mother had died of lung disease. She had been born and bred-up in or near Göteborg, and had lived largely on fish both fresh and salted. She had been strong and healthy from her childhood to the commencement of her leprosy. Those who, with the writer, regard leprosy as fish-eaters' tuberculosis will note with interest that both parents had died of "lung disease."

KISSING AND SYPHILIS.

WHEN Dr. M., in the *Twentieth Century of Medicine* states that "it is well known that kissing represents one of the most common modes of syphilitic contagion," one is at a loss to know what meaning to attach to his words. Chancres on the lips are, in English practice, very rare, and probably but few even of them actually result from kissing. Contagion from towels, drinking vessels, and the like, probably explains almost all of them.

This most astonishing statement is made in order to imply a probability that leprosy is communicated in the same way. But in reply to this we have the fact that never in any single case has anything of the nature of a primary leprosy sore been observed on the lip. Such primary sores have, in fact, never been observed anywhere. So far as any proved facts go they are non-existent.

NOTES OF A CONVERSATION WITH A PERSIAN PHYSICIAN.

THESE notes record what I was told by Mirza Sace'd, a well-informed physician. The Mirza had attended my clinical lectures at Park Crescent some years ago and had become familiar with my views as to the connexion of fish-eating with leprosy. He had also seen many examples of the disease and had become skilled in its diagnosis. On his return to Persia he made leprosy an especial subject of observation during his travels. The statements are of importance because it has been often asserted that there is no fish-eating in the highlands of Persia.

He has just returned from travel through Persia. His father was a priest at Semnah, Kindistan. His father sometimes himself washed dead lepers. It was then the custom to drive a leper out of the town.

He says that people in England have no idea how much fish is consumed in the highlands of Persia.

Resht on the Caspian supplies to Persia a certain quantity of fish in a dried or salted condition.

Kezelvezan is a great river having its source in Kindistan and emptying into the Caspian. Khamsa, is a district on the river where fish is both dried and salted and kept for winter food. There are many lepers there.

At Hamadan, in Persia, most of the lepers met with have come from Khamsa. It was here that Mirza Sace'd, my informant, had practised.

"In *Dizful*, 30,000 inhabitants. Every day 7,000 pounds of fish used. It is chiefly cured fresh, fried in oil. I did not see a single case of leprosy. I was there three months and I made careful enquiry; no salting is done. Plenty of cereals and fruit.

"*Sakez*, a town in Kindistan, 5,000 inhabitants. There eczema, &c., are common and are often confused with leprosy. The patients go to a certain popular native doctor, who is skilful in eczema and with them come many lepers.

"In this town is a large river and fish is eaten all the year round. There are forty fishermen. It is said that they do not salt fish. There is a leper colony reputed to have sixty lepers. Very large fish are caught.

"*Banah* is another town under similar conditions, much fresh fish and many lepers on the Caspian. I enquired carefully. Two natives of Resht had leprosy.

"*Auzali* is an island (in Persian ownership) in the Caspian where salted fish is made for the Persian market. There are some lepers on this island. They have a prejudice against fish as a cause of leprosy and if anyone has a little sore they tell him not to eat fish or it will turn to leprosy.

"At *Hamadan* (6,200 feet above sea level) where I lived, I have seen two cases of leprosy in natives one of whom had never left the place. In this town every winter a good deal of salted fish is brought from Resht and sold, much fresh fish is also taken from the river and irrigation canals. There is a small leper colony just outside the town but all the inmates have come from a distance."

Mirza S. has known many instances of husband and wife living together without infection and of their having quite healthy children.

Avicerina refers to fish as a cause of leprosy and also dried meat. He refers to the abundance of the disease in Alexandria.

Dr. Schlenner, who was medical teacher in Teheran twenty years ago, has written a Persian Medical Dictionary. In it he states that he had seen near the Caspian a male leper who was from Khamsa, who was living with his wife and mother under conditions which convinced Dr. S. that it was not a contagious disease. Dr. S. does not mention having ever seen lepers in Teheran. He says that he does not believe in the fish theory because they eat a great deal of fish on the shores of the Persian gulf and do not get leprosy. It is suggested that this exemption is because they never keep their fish more than six hours and always fry it to dryness.

Mirza S. has been in Teheran and has seen several lepers in the streets. Much fish, salted, dried, and fresh, is consumed. The journey for fresh fish over the mountains from the Caspian is about twenty-four hours. Fresh fish is packed with ice.

In Turkmanchai in the mountains, a large reservoir used formerly to supply plenty of fish. There was much leprosy. A flood destroyed the lake and since then there have been no new lepers. The majority of the old ones were killed off by a doctor who prescribed mercury in large quantities. It may, therefore, be asserted that both segregation and fish abstinence measures were tried simultaneously.

In Goyaghaj, a large village, in Afshar, 5,000 feet, the Mirza found some leprosy (fourteen cases). It was assumed by the Mirza's companion (a physician) that at such altitude there would be no fish-eating. They found, however, on enquiry that there was a large river a few miles down where much fish was caught and supplied to the village.

These statements entirely dispose of the assertions that cured fish is not obtainable in the upper districts of Persia, and show that in the main the supply of it is in ratio with the prevalence of leprosy.

J. H.

PROFESSOR HALLIBURTON ON THE BACTERICIDAL PROPERTIES
OF THE BLOOD.

We quote the following from the *Times* report of the British Association for the Advancement of Science:—

The power the blood possesses of slaying bacteria was first discovered when the effort was made to grow various kinds of bacteria in it; it was looked upon as probable that blood would prove a suitable soil or medium for this purpose. It was found in some instances to have exactly the opposite effect. The chemical characters of the substances which kill the bacteria are not fully known; indeed, the same is true for most of the substance we have to speak of in this connection. Absence of knowledge on this particular point has not, however, prevented important discoveries from being made. So far as is known at present, the substances in question are proteid in nature. The bactericidal powers of blood are destroyed by heating it for an hour to 56° C. Whether the substances are enzymes is a disputed point. So also is the question whether they are derived from the leucocytes; the balance of evidence appears to me to be in favour of this view in many cases, at any rate, and phagocytosis becomes more intelligible if this view is accepted. The substances, whatever be their source or their chemical nature, are sometimes called alexins, but the more usual name now applied to them is that of *bacterio-lysins*. Closely allied to the bactericidal power of blood, or blood-serum, is its globulicidal power. By this one means that the blood-serum of one animal has the power of dissolving the red blood corpuscles of another species. Another interesting chemical point in this connection is the fact that the bactericidal power of the blood is closely related to its alkalinity. Increase of alkalinity means increase of bactericidal power. Alkalinity is probably beneficial, because it favours those oxidative processes in the cells of the body which are so essential for the maintenance of healthy life. Normal blood possesses a certain amount of substances which are inimical to the life of our bacterial foes. But suppose a person gets run down; everyone knows he is then liable to "catch anything." This coincides with a diminution in the bactericidal power of his blood. But even a perfectly healthy person has not an unlimited supply of bacterio-lysin, and if the bacteria are sufficiently numerous he will fall a victim to the disease they produce. Here, however, comes in the remarkable part of the defence. In the struggle he will produce more and more bacterio-lysin, and if he gets well it means that the bacteria are finally vanquished, and his blood remains rich in the particular bacterio-lysin he has produced, and so will render him immune to further attacks from that particular species of bacterium. Every bacterium seems to cause the development of a specific bacterio-lysin. Immunity can more conveniently be produced gradually in animals, and this applies, not only to the bacteria, but also to the toxins they form. If, for instance, the bacilli which produce diphtheria are grown in a suitable medium, they produce the diphtheria poison, or toxin, much in the same way that yeast-cells will produce alcohol when grown in a solution of sugar.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

THE TREATMENT OF SEVERE DYSMENORRŒA.

BY PETER HORROCKS, M.D., F.R.C.P.

[*Abstract.*]

THE lecture was concerned with the varieties of pain that may be associated with the menstrual period, the causes of such pain, and the methods by which relief may be afforded. It is rare to find menstruation absolutely free from discomfort, but this is usually slight and does not of itself suggest any need for medical advice. In other cases, however, there is a degree of suffering sufficient to compel the patient to seek relief. The majority of these sufferers are more or less successfully treated by such measures as rest, hot applications, and various drugs. But in certain instances the pain is extreme, or even agonising, and is found to resist all the simpler hygienic and medicinal remedies. Pain of this order may originate in an abnormal condition of the uterus, ovary, or Fallopian tubes; it may be associated with the results of intra-pelvic inflammations; and occasionally it would appear to be neuralgic in nature, and to occur apart from any recognisable organic disease. An attempt should always be made to determine the source of the pain, though this is not always successful, as there may be several causes in one and the same case, or, as already stated, the pelvic organs may be normal to physical examination. Broadly speaking, the ovary is suggested when the pain commences a day or two before the menstrual flow, whilst, when the onset of the pain coincides with, or is aggravated by the flow, the uterus is usually at fault. The discharge of blood-clots or of pieces of membrane also

favours a uterine origin. For the most part the cases in which the pain is associated with the uterus are more readily cured than those where the ovary is responsible for the pain. The question of treatment becomes specially prominent when the usual means of relief fail, and when each menstrual period is the occasion of extreme and severe suffering. In all it is right to give a fair and reasonable trial to the effects of rest, hot applications, bromides and similar drugs, and change in environment—a warm climate, for example, will sometimes mitigate pain accompanying a too scanty flow. But when such means fail and the pain is urgent and commanding, more heroic measures must needs be contemplated. The temptation to use morphine ought to be steadily resisted. Generally, when once commenced, the demand for the sedative increases, and the patient runs a considerable risk of becoming a victim to the morphine habit. To relieve an emergency a dose of morphine may be necessary, but the fact that such treatment is required is in itself a proof that the case requires careful study with a view to discover a method calculated to afford permanent relief. What is true of morphine is true also of alcohol, which, in the form of gin, is a popular cure for dysmenorrhœa. The line of treatment which may be wisely followed in the more obstinate and severe cases is as follows :—(1) Dilatation of the os uteri, using Hegar's dilators up to No. 9 or 10 shortly before the onset of the period ; if this is successful there is reason to believe that a modified Sim's operation would give permanent relief, and such an operation should therefore be advised. (2) In cases of membranous dysmenorrhœa curetting of the uterus, followed by the application of a caustic to the uterine wall, should be tried. (3) When such measures fail, the question of removal of one or both ovaries comes into view. Sometimes one of the ovaries may be found on vaginal examination to be enlarged, prolapsed, or tender, and given the circumstances just explained, it would be reasonable to remove this by the vaginal route. But when no such indication exists, and the pain is sufficient to spoil the patient's life, it is legitimate to remove one of the ovaries, even though vaginal examination fails to reveal any abnormal condition of the organ, and in such circumstances it is better to proceed by an abdominal incision. There is still another possibility, viz., the persistence of the pain in spite of such an operation. Such a position

is one of much anxiety, for nothing now remains but the removal of the second ovary. Before taking such a step a prolonged opportunity should be given to allow the effects of the earlier operation to manifest themselves, and only when the result is negative and the extremity of suffering is great should a further operation be advised. In some very rare cases, however, both ovaries should be removed at the first operation. The effects of the measure should be carefully and thoroughly explained to the patient, and it is in the highest degree advisable that the necessity for the operation should be recognised by two or more expert advisers.

[The several aspects of the lecture were illustrated by the narration of clinical records from the lecturer's hospital and private practice.]

THE TOPOGRAPHICAL DIAGNOSIS IN CASES OF PARALYSIS.

BY JUDSON S. BURY, M.D.LOND., F.R.C.P.

Physician to the Manchester Royal Infirmary.

[*Abstract.*]

DR. JUDSON BURY'S lecture was a reasoned presentation of the anatomical and physiological facts on which are based the principles of regional diagnosis in the various forms of paralysis. It is manifest that in every case of loss of motor power there must be either disease of the paralysed muscles, or an interruption of the nerve impulses by which in health the muscles are thrown into voluntary contraction. In the great majority of cases the defect is of the latter variety, and hence in order to determine the site of the lesion it is necessary to remember the anatomical course of the motor nerve pathway and to recall the functions of its several parts. Voluntary motor impulses undoubtedly take origin in the large cells of the cerebral cortex in the immediate neighbourhood of the fissure of Rolando, and more particularly in the nerve-cells of the ascending frontal convolution. Thence nerve-fibres travel through

the white matter of the cerebral hemisphere and, converging as they descend, are gathered together in the internal capsule of the corpus striatum. Next they are to be traced through the crus cerebri, and into the pons Varolii. Here the fibres which convey impulses governing the movements of the facial and lingual muscles cross the middle line to terminate in association with the facial and hypoglossal nuclei of the opposite side. The fibres which are associated with movements of the limbs, on the other hand, continue through the pons into the medulla. There the great majority of them cross at the decussation of the pyramids to descend in the posterior part of the lateral column of the spinal cord (crossed pyramidal tract). The termination of these fibres is found in the form of arborescent ramifications in the neighbourhood of the multipolar nerve-cells of the anterior cornu, and the portion of the motor tract extending from the motor cells of the cerebral cortex to the branching of the fibres of the pyramidal tract in the grey matter of the spinal cord, may be named the upper or cerebro-spinal segment. From the multipolar cells of the anterior cornu issue fibres which are grouped into the anterior roots of the spinal nerves, and are continued through the peripheral nerves to the muscles. It is these fibres, together with the spinal nerve-cells in which they take origin, that constitute the inferior or spino-muscular segment of the motor tract. The first step towards a regional diagnosis in any case of paralysis depends upon a knowledge of the elementary facts just stated. At the very outset arises the question—Is the lesion in the upper, or in the lower segment of the motor tract? If in the upper, the paralysis will be accompanied by spasm (spastic rigidity) and by exaggeration of the tendon jerks and will involve large groups of muscles, as, for example, all the muscles of a limb. A lesion in the lower segment, on the contrary, is distinguished by atrophy and flaccidity of the involved muscles and by loss of the tendon jerks; further, the distribution of the paralysis is marked by limitation to an individual muscle or group of muscles, and does not usually extend to several associated or opposed groups. The explanation of these differences is to be found in the trophic influence and reflex function of the nerve-cells in the anterior cornua of the cord. So long as the lesion is above the physiological level of these cells, the nutrition of the muscles remains satisfactory, and the tendon jerks remain

active. But with a lesion in the lower segment, the trophic control of the muscles is removed, and the reflex arc is broken—hence the paralysis is accompanied by atrophy, and the tendon jerks cannot be evoked. The value of these doctrines may be illustrated by considering some common forms of paralysis from the point of view of regional diagnosis. Take in the first place a case of simple hemiplegia—a paralysis involving the limbs and face on one side of the body. The lesion, we conclude, is in the upper motor segment, because the paralysis is not accompanied by muscular atrophy; it involves more or less all the muscles in the parts affected; and sooner or later it is accompanied by spastic rigidity and exaggeration of the tendon jerks. Again, it is a natural presumption that as the paralysis is confined to one side of the body the lesion is in that part of the upper segment which passes through the brain, for here the two tracts are widely separated, and a single lesion will almost certainly be limited to one of them, whereas in the cord they are in close juxtaposition and may readily, therefore, be both damaged by one and the same casualty. Pushing the analytical process still further, it is obvious that as the limbs and face are involved on one and the same side, the lesion must be on the opposite side of the brain, and at a level above the point at which any decussation of fibres occurs, that is, above the middle of the pons, where the facial tract crosses the middle line. The crus cerebri may be excluded, because through its substance passes the third cranial nerve, injury to which would express itself in the form of ptosis, external squint, etc., on the same side as the lesion, that is on the side opposite to the hemiplegia. If in or near the cortex a lesion to involve all parts (face, arm, leg) of the motor tract would have to be a very extensive one, as the centres and fibres are here spread out over a relatively large area, and so extensive a lesion is hardly compatible with the preservation of life. Hence the cortex as well as the crus cerebri may be excluded. There remains only the internal capsule, where the various strands of the tract are so close together that they are readily commanded by a single small lesion, and it is here that experience shows the lesion to be usually situated. Thus in considering the anatomical diagnosis in an ordinary hemiplegia we proceed by a series of steps to the conclusions, (1) that the lesion is in the upper motor segment; (2) that it is in the brain

part of the segment, (3) that it is on the side of the brain opposite to the paralysis and above the level of the pons, (4) that the absence of paralysis of the third nerve shows the lesion not to be in the crus, (5) that the affection of both limbs and of the face renders the cortex a highly improbable site, and (6) that the anatomical diagnosis in such a case refers the lesion to the only remaining part of the motor tract, viz., the internal capsule. No doubt an ordinary hemiplegia is a simple problem for anatomical diagnosis, and its explanation is so often a matter of *post-mortem* demonstration that we do not consciously proceed by a logical series of steps to our conclusion. All the same it is necessary to keep these steps clearly before us, because the habit of mind which they establish is essential to the solution of problems much more difficult than the one presented by a case of hemiplegia. The same principles of diagnosis may be further illustrated by considering a case of spastic paraplegia. There is tonic spasm and exaggeration of the tendon phenomena—the lesion is therefore in the upper motor segment. As both the lower limbs are involved the lesion must be in a situation where the two tracts are close together. There are only two such situations. The one is the spinal cord, the other the vertex of the cerebral hemispheres, where, on each side of the middle line and around the upper part of each Rolandic fissure, are grouped the centres which control the movements of the lower limbs. The anatomical diagnosis lies, therefore, at one or other of these positions. As a matter of experience it is found that spastic paraplegia in early childhood depends on a cortical lesion, whereas in older patients the presumption is in favour of a spinal origin. The common type of birth palsy is a spastic paraplegia dependent on a meningeal hæmorrhage or degenerative changes involving the lower limb-centres at the summit of the cerebral hemispheres, and evidence in support of the anatomical diagnosis may usually be found in depreciation of the mental faculties or in some degree of rigidity of the upper limbs, the injury extending from the centres of the lower limbs into adjacent regions of the cortex. A similar condition may be the result of a diffuse meningo-encephalitis, the consequence of syphilis, and the distinction of this from ordinary birth palsy can often only be made by means of the history or by the existence of other evidences of hereditary specific disease. In older children and in adults, as already stated, the pre-

sumptive anatomical diagnosis places the lesion in spastic paraplegia in the spinal cord, and as it is the upper motor segment which is damaged it is evident that the lateral columns must be the site of the disease. The next step in such a case is to look for evidence of disease originating outside the cord and damaging the cord by pressure or irritation as, for example, caries of the spine, a tumour, or pachymeningitis. Pains radiating round the trunk or extending into the limbs will suggest irritation of the posterior roots, whilst muscular atrophy will have a similar relationship to the anterior roots. In the absence of such signs the primary condition may be concluded to be one of myelitis, and the extension of the lesion to the grey matter of the cord may be shown by anæsthesia and by defect in the functions of the bladder and rectum. The extent of the anæsthesia will be a guide to the level of the cord to which the lesion has reached, whilst the persistence of rigidity in the limbs and of exaggerated tendon jerks will show that the centres of the lower part of the cord are intact, though cut off from their normal connection with the voluntary centres in the brain. Destruction of these centres would be, of course, an invasion of the lower motor segment and would be attended by muscular wasting and loss of the tendon jerks. In some cases in adults it must be admitted there is apparently a pure spastic paraplegia characterised by various degrees of spasm and paralysis and by heightened tendon phenomena, but without sensory or visceral disturbances. Are these, therefore, cases of unqualified primary lateral sclerosis? This is, at least, very doubtful. Some, undoubtedly, prove to be cases of disseminated sclerosis, the early sclerotic patches having, so to speak, selected symmetrical positions in the pyramidal tracts. In others careful search will usually detect some evidence, *e.g.*, absence of the abdominal reflexes on one side, that the grey matter of the cord as well as the lateral columns is involved in the pathological process.

Disease of the lower motor segment is distinguished, as already explained, by the fact that the paralysis is accompanied by atrophy—it produces, in short, atrophic paralysis, loss of tendon jerks, and in well-marked cases, the reaction of degeneration. If the atrophic paralysis extends to all the muscles supplied by a single nerve, *e.g.*, the facial, the presumption is that the lesion is in the nerve trunk; should the condition affect a group of muscles all of which are not

supplied by one and the same nerve, the nerve-cells of the cord or the anterior roots come under suspicion ; whilst in the case of a more generalised atrophic paralysis the diagnosis lies between a chronic anterior polio-myelitis (progressive muscular atrophy), a progressive generalised peripheral neuritis, and a congenital muscular dystrophy or myopathy. Aid in establishing a distinction may be obtained by observing the distribution of the paralysis. Progressive muscular atrophy usually commences in the small muscles of the hand and only affects at a later date the muscles about the shoulder ; it rarely or never invades the upper part of the trapezius, the levator anguli scapulæ, or the platysma myoides. Myopathies, on the contrary, frequently commence and may remain confined to the region of the shoulder girdle ; they often, too, affect the muscles which progressive muscular atrophy spares ; and atrophy of the lower part of the pectoralis major or of the latissimus dorsi are facts strongly suggesting that the affection is myopathic in nature. Progressive muscular atrophy, further, is distinguished by fibrillary contractions in the affected muscles, by an alteration in the electrical reactions, and by the gradual and equal march of paralysis and atrophy. In myopathies there is no fibrillation, no electrical changes, at least, not until the muscular wasting has become extreme, the atrophy rather than the paralysis is the dominating note, and some of the muscles may undergo a pseudo-hypertrophy. In multiple peripheral neuritis the nerve trunks are the site of the diseased process, and thus there are sensory symptoms, pain, anæsthesia, etc., in addition to the paresis. This fact usually suffices to separate neuritis from an affection of the anterior cornua, but rarely a pure motor neuritis occurs, and the distinction from a cord lesion may then be attended with much difficulty.

In addition Dr. Judson Bury discussed the occurrence of muscular atrophy as a reflex result of disease of joints, and also the development of atrophy in long-standing hemiplegias as showing the influence of the higher on the lower motor neuron.

SOME POINTS IN THE PROGNOSIS OF HEART DISEASE.

BY P. H. PYE-SMITH, M.D., F.R.C.P., F.R.S.

[*Abstract.*]

IN the first part of his lecture, Dr. Pye-Smith discussed—as a question necessarily exercising a commanding influence over prognosis—the necessity of establishing a distinction between cardiac murmurs due to organic valvular disease, and those of functional origin and significance. In many cases there is no room for uncertainty. The double murmur of aortic valve disease, and the rough pre-systolic bruit of mitral stenosis, are, for example, auscultatory facts, each open only to one explanation. But in not a few instances the confident interpretation of a murmur heard in the cardiac area as significant of organic disease on the one hand, or of functional disturbance on the other, is a task of no little difficulty, and one that calls for exact and careful observation, deliberate judgment, and, not infrequently, repeated examinations and a delayed decision. As general considerations helping towards a solution of the problem in individual cases, it may be remembered that a diastolic or pre-systolic murmur always mean organic disease; that the same is true of a systolic murmur heard at the apex and conducted with distinctness to the left axilla and round to the angle of the left scapula; and that a similar conclusion must be attached to a murmur which, heard more or less doubtfully when the patient is standing upright, becomes distinct when he is lying down. Help may, in addition, be obtained from an examination of the pulse, and from the history of the patient, including or excluding, for example, an attack of rheumatic fever.

Regarding the degree of gravity of the various valvular lesions, the late Dr. Peacock placed aortic stenosis as the least serious, mitral stenosis next, then mitral regurgitation, and, most grave of all, aortic regurgitation. This classification may be accepted as true, so far as it goes, but in dealing with the prognosis of an individual case, many circumstances other than the nature and site of the lesion come in to modify it. One of these is the cause of the valvular flaw.

Thus, a definite history of a rheumatic attack—including in this not only rheumatic fever, but also chorea and post-scarlatinal rheumatism—improves the prognosis, other things being equal; and the greater the lapse of time since the incidence of such a cause, and without the emergence of cardiac disturbance, the greater the probability that the valvular defect is not of a serious or crippling character. The loudness of the murmur has little or no bearing on prognosis. The main question to be determined is whether the circulation is or is not being efficiently conducted. Absence of the symptoms of cardiac disease, a regular pulse not excessively accelerated by exertion, and the absence of breathlessness after moderate exercise, mean successful adaptation of the cardiac muscle to the abnormal physical conditions created by the valvular defect; and when effective compensation is indicated in this fashion, the prognosis is relatively good even in cases of aortic regurgitation. It must be carefully noted that whilst the signs of cardiac hypertrophy are of good import in so far as they mean efficient compensation, the degree of the hypertrophy is a measure of the severity of the valvular defect. Hence, for example, in aortic regurgitation a large left ventricle is a cause for some satisfaction. It means a vigorous and capable cardiac muscle. But it also means the necessity for much hypertrophy, and, therefore, is an index that the degree of regurgitation at the aortic orifice is considerable. In such a case the prognosis cannot be so good as in one where, with the complete absence of cardiac symptoms, there is little or no evidence of enlargement of the heart. The hypertrophy is a measure of the abnormal strain placed upon the muscle. It may be taken to show that, so far, the heart is equal to this strain; but sooner or later there will be exhaustion of the capacity of the muscle, the hypertrophy will be succeeded by dilatation, and the heart will prove unequal to the task of carrying on the circulation. Hence, absence of cardiac symptoms, together with non-enlargement of the heart, is better than absence of symptoms with more or less hypertrophy, while worst of all is it to have breathlessness, dropsy, or other signs of circulatory failure in spite of considerable cardiac enlargement, for the latter in these circumstances means a collapse of the compensation which had formerly been secured.

The question of liability to sudden death is one almost always

raised by the patient or his friends when a diagnosis of organic heart disease has been given, and there is no doubt that such disease is accountable for the great majority of sudden deaths. Of the various valvular lesions it is beyond dispute that aortic regurgitation is by far the most serious in this respect. And it must be added that the liability to sudden death is greater in patients who have efficient compensation, who enjoy a fair measure of health, and are able to indulge in ordinary activities, than it is in those in whom compensation is beginning to fail. In the latter case the patient, in consequence of dilatation of his left ventricle, will have more or less mitral regurgitation, and the tendency of events is now not towards sudden arterial anæmia, but to a gradual overfilling of the veins. Hence it becomes the duty of the physician to warn the patient with efficient compensation—and also his friends—of the danger of sudden death if any excessive stress is made upon the circulation, whilst at the same time an assurance may be given that care in this direction will probably secure many years of useful and enjoyable life. On the other hand, whilst the evidences of failing compensation call for restricted activities, they carry with them some consolation in the shape of a diminished liability to sudden death.

Hæmoptysis as a symptom of heart disease is not a ground for alarm. Indeed, many patients are much relieved by it, and it is probably never a cause of death in valvular disease. The old notion that the entrance of the blood into the lungs might form the starting-point of pulmonary phthisis is quite unfounded; there is no such thing as a *phthisis ab hæmoptœe*. So far as the progress of pulmonary tubercle is concerned, it is probable that organic heart disease is a retarding influence when the two conditions happen to be present in one and the same patient. Hæmoptysis is most common in cases of mitral stenosis, next in those of aortic regurgitation, and it is very rare in mitral incompetence.

In the non-valvular forms of heart disease prognosis varies within wide limits. In *obesity of the heart*, as seen in stout patients of alcoholic habits, there is great danger of sudden death; the muscular substance becomes atrophied before the advancing fat and may be reduced to a layer so thin as hardly to separate the pericardium from the endocardium. *Fatty degeneration* of the

cardiac muscle, on the other hand, is a condition the danger of which is much exaggerated. Its existence is to be inferred on general pathological grounds, as, for example, the presence of "pernicious" anæmia or poisoning by phosphorus; the usual grounds stated for its diagnosis have been rather thought out in the study than observed at the bedside. *Fibrous degeneration* of the heart wall may be a syphilitic manifestation and may be associated with the presence of gummata or with specific end-arteritis of the coronary arteries; in other cases it is a consequence of arterial disease leading to thrombosis and imperfect vascular supply of the heart wall. The condition is difficult or impossible to recognise during life, it carries a definite risk of sudden and fatal syncope, and is hardly amenable to treatment.

The prognosis in the comparatively rare cases of considerable disturbance of the rate of the pulse, without evidence of cardiac valvular disease, is not good either in increase or diminution of the rate. *Persistent tachycardia* extending over weeks, months, or years, is a serious condition, apt to lead to hypertrophy or dilatation of the heart, and attended with some risk of sudden death. Similarly an *excessively slow pulse*, at least in its more extreme degrees, is a dangerous condition. Occasionally it is found in early life, and in some cases it is associated with convulsive seizures. Of each of these two states of the pulse it has to be said that the pathology is obscure and the treatment unsatisfactory.

Dr. Pye-Smith concluded his lecture by relating seven case-records to show (1) that organic heart disease is, if proper precautions are observed, often compatible with a prolonged and useful life; (2), that treatment, as above described, may successfully—and sometimes on repeated occasions in the same patient—restore the efficiency of the circulation even when the symptoms are unpromising; and (3) this applies to extreme dropsy from chronic mitral disease, to long standing aortic imperfection in old as well as in young patients, in cases of atheromatous as well as in those of rheumatic origin, and even in some few cases of septic endocarditis.

ON AUTO-INTOXICATION.

BY ALLAN MACFADYEN, M.D., B.Sc.

[*Abstract.*]

THE processes of disease may be referred in some instances to the influence of agents external to the body, and in other cases to the action of agents of internal origin. The terms infection and intoxication are, broadly speaking, the respective names applied to these two modes of action of the material causes of disease. The distinction is not, however, an absolute one. Thus infection of the body by an external agent may in certain cases produce all the symptoms of an intoxication, and, on the other hand, the substance on which an intoxication depends may be traced in the last resort to the operation of an infective agent. Micro-organisms capable of self-multiplication within the body are the typical infective agents from without, and their entrance and subsequent activity within the economy may issue in the intoxication of the whole body. Again, the cause of an intoxication may be a substance dependent on a living organism, though the organism itself remains external to the body. Alcohol as the result of the activity of the yeast plant may be mentioned as an example, and a large group of food poisons belong to the same category. In other cases the intoxicating agent takes origin outside the body independently of living cells, as, for example, with noxious gases and various chemical substances. And even when a true infection occurs, the local effects may be relatively insignificant, and the serious clinical results which follow may be wholly due to the intoxication of the tissues by the poisons elaborated at the seat of invasion. Diphtheria and tetanus may be quoted as examples of events of this order. Indeed, the general tendency of recent experimental work suggests that all living agents which cause disease do so in virtue of the toxins they produce—that is to say, that the essential part of an infection as a clinical occurrence is the intoxication to which it indirectly gives rise. Such statements as the above are sufficient to show how close is the association between the ideas suggested by the contrasted terms

infection and intoxication. It is perhaps somewhat easier to draw a line between auto-infection and auto-intoxication, though sometimes they are used as synonymous terms. Auto-infection may be conveniently used to indicate the development of diseased processes in other parts of the body as the result of the transference of a morbid agent from the primary seat of disease. It will thus include such events as the occurrence of metastatic abscesses in pyæmia, of empyema in enteric fever, etc., etc. Auto-intoxication may be defined as a condition due to poisons produced in the body as the result of a depraved or abnormal metabolism. The complicated series of chemical changes through which the food-stuffs pass between their ingestion and their elimination in the form of carbonic acid, urea, etc., may, it will be readily understood, either be deflected from their normal course or be imperfectly accomplished. In each case the tissues will be subjected to the operation of an agent abnormal either in quality or amount. Again, a check to the processes of elimination will produce a parallel result, and such conditions as asphyxia, uræmia, cholæmia may be quoted as examples of auto-intoxication.

Diabetic coma is another illustration of the doctrine of auto-intoxication, and the appearance of indican and other abnormal bodies in the urine in various conditions may be taken as proof of the poisoning of the tissues by the products of disturbed metabolic processes. The study of these abnormal chemical processes is one of great difficulty. Even the physiological chemistry of the body is known but imperfectly, and the exact nature of the pathological processes which produce auto-intoxication is a laborious and difficult branch of study. It includes the chemistry of digestion, absorption, assimilation, and excretion, for disturbance in any one of these processes may give rise to abnormal substances and to auto-intoxication. Especially important is the study of the intermediate products of metabolism—that is, the study of those substances which are produced as mere stages in the metabolic movement, and which, therefore, in health are found in the tissues and excretions only in sparing amount. This is the position of such bodies as kreatin, cystin, oxalic acid, grape sugar, lactic acid, etc., and the relationship of these substances to the doctrine of auto-intoxication is due to the fact that in circumstances of which we have but an

inadequate knowledge they may be produced in abnormally large quantities, and, being absorbed by the blood, may have a prejudicial influence on various parts of the body. It is sufficient to mention the complicated changes through which the proteids are conducted in the processes of digestion, assimilation, etc., to show how by an interruption of these processes abnormal agents may be readily introduced in quantity into the blood stream and tissues.

Another group of bodies by which auto-intoxication may be produced are the *leucomaines*. These are alkaloidal bodies found in the tissues in health, and the products of normal physiological processes. If from any cause these are formed in excessive quantity, or are allowed to accumulate in the tissues, they may give rise to a toxæmia.

The possible forms which auto-intoxication may assume, have been classified as follows :—

(1) Those resulting from a failure of function in certain organs, with, as a consequence, non-neutralisation of poisonous metabolic products; myxœdema, pancreatic diabetes, acute yellow atrophy of the liver, and Addison's disease are examples.

(2) Those due to metabolic anomalies whereby intermediate metabolic products enter the circulation, as occurs in gout and diabetes.

(3) Those resulting from the retention of metabolic products in various organs, as seen in the symptoms following severe burns, carbonic acid poisoning, and uræmia.

(4) Those dependent on the over-production of physiological and pathological products, instances being acetonuria, cystinuria, and diabetic coma.

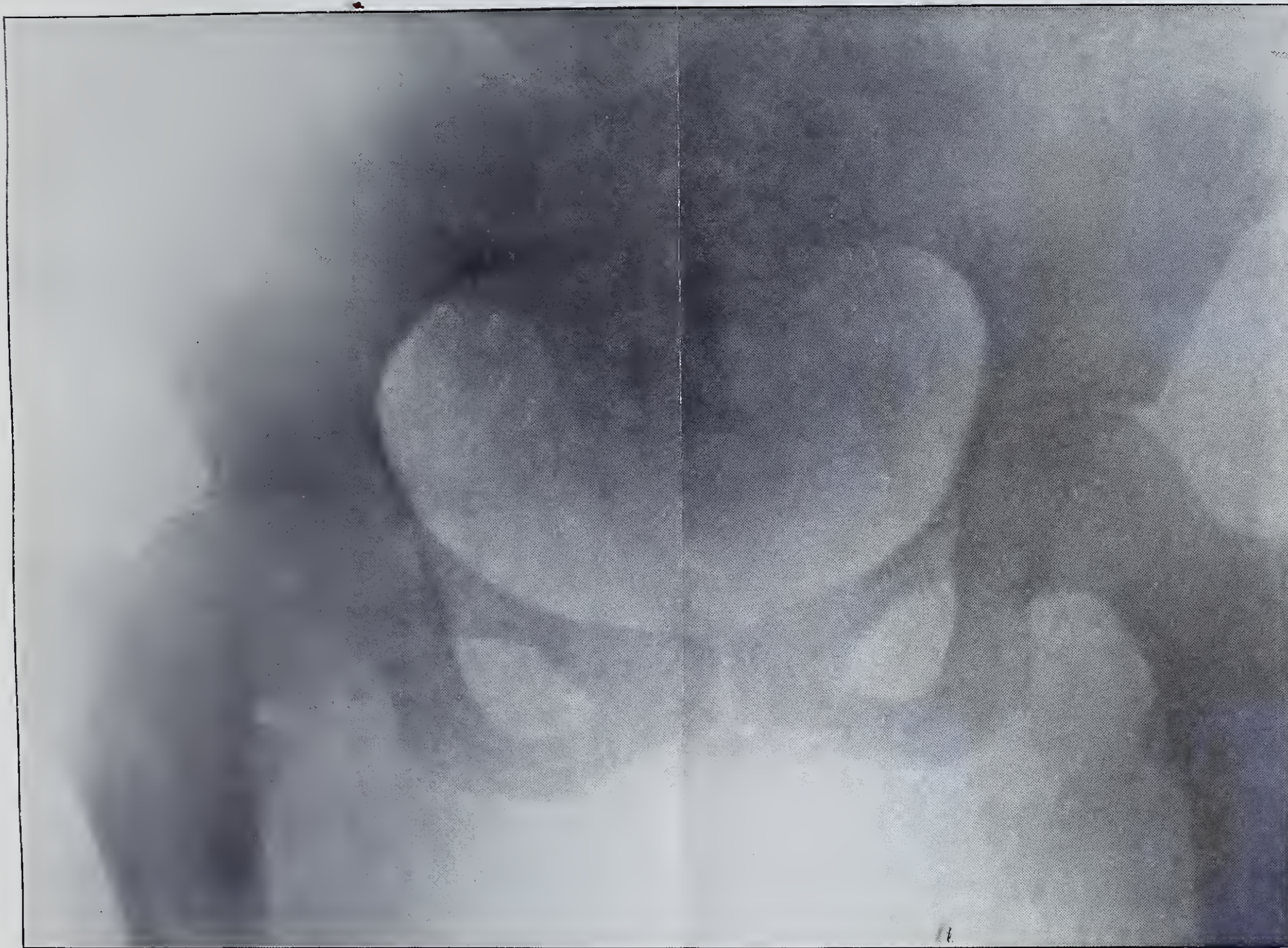
Such a classification shows that an auto-intoxication may originate in a disturbance in almost any part of the body, and it requires to be extended by the inclusion of certain acute and chronic forms of dyspepsia, which, by abnormal fermentations, give rise to the absorption of poisons from the alimentary canal.

The explanation of the comparative infrequency of auto-intoxication is probably to be found in the physiological arrangements by which poisons produced in the body are neutralised or eliminated. The kidneys are the most important excretory channel, though the skin, lungs, and bowel, all have a share in this work, whilst on the liver falls the responsibility of neutralising the toxic substances

which are absorbed from the intestine. Probably it is failure of this last-mentioned duty that gives rise to the phenomena of a bilious attack.

The symptoms of auto-intoxication may be displayed in (1) the skin as anæmia, bronzing or other colour change; (2) the intestine, *e.g.*, flatulence, colic, diarrhœa, etc., with which may be associated as the result of toxic absorption, headache, migraine, and other secondary disturbances; (3) the kidneys giving rise to albuminuria, hæmaturia, oxaluria, etc.; (4) the nervous system in the form of headache, giddiness, insomnia, melancholia, etc., these giving rise ultimately to disturbances of the heart and respiration; (5) in the blood, thus causing anæmia, chlorosis, diabetes, the uric acid diathesis, etc.

One of the main sources of poisons giving rise to auto-intoxication is the chemical changes which occur in the alimentary canal in connection with the digestion of food. Dr. Macfadyen gave an outline of these changes, and of the various substances produced from the carbohydrate and proteid food-stuffs. He also alluded to the protective influence of the liver; to the different degrees of susceptibility exhibited by different individuals to the presence of poisons in the blood and tissues; and to the difficulty or impossibility of meeting the production of poisonous substances in the intestine by the administration of intestinal antiseptics. In conclusion, he referred to diabetic coma, pernicious anæmia, chlorosis, fatigue fever, etc., as further illustrations of the thesis that auto-intoxication plays an important rôle in the production of disease.

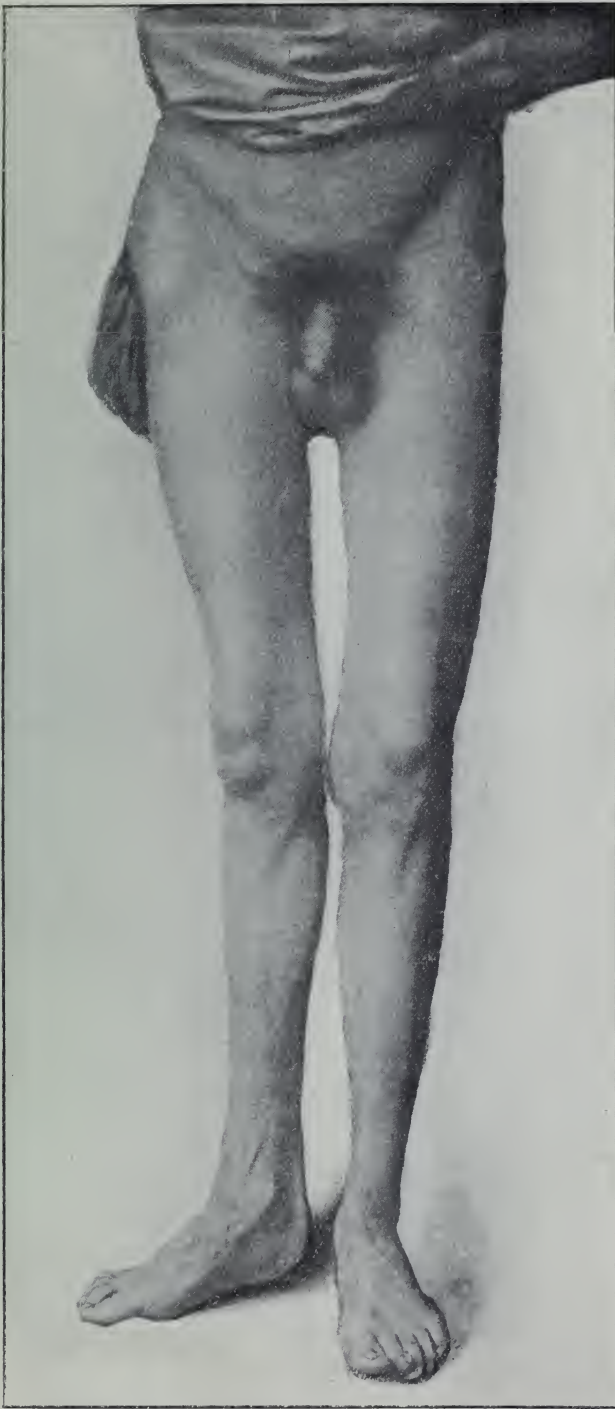


Coxa vara of the right hip in a young adult. (From a radiograph lent by Mr. Robert Jones, of Liverpool, taken [No. 308] by Dr. David Morgan.)

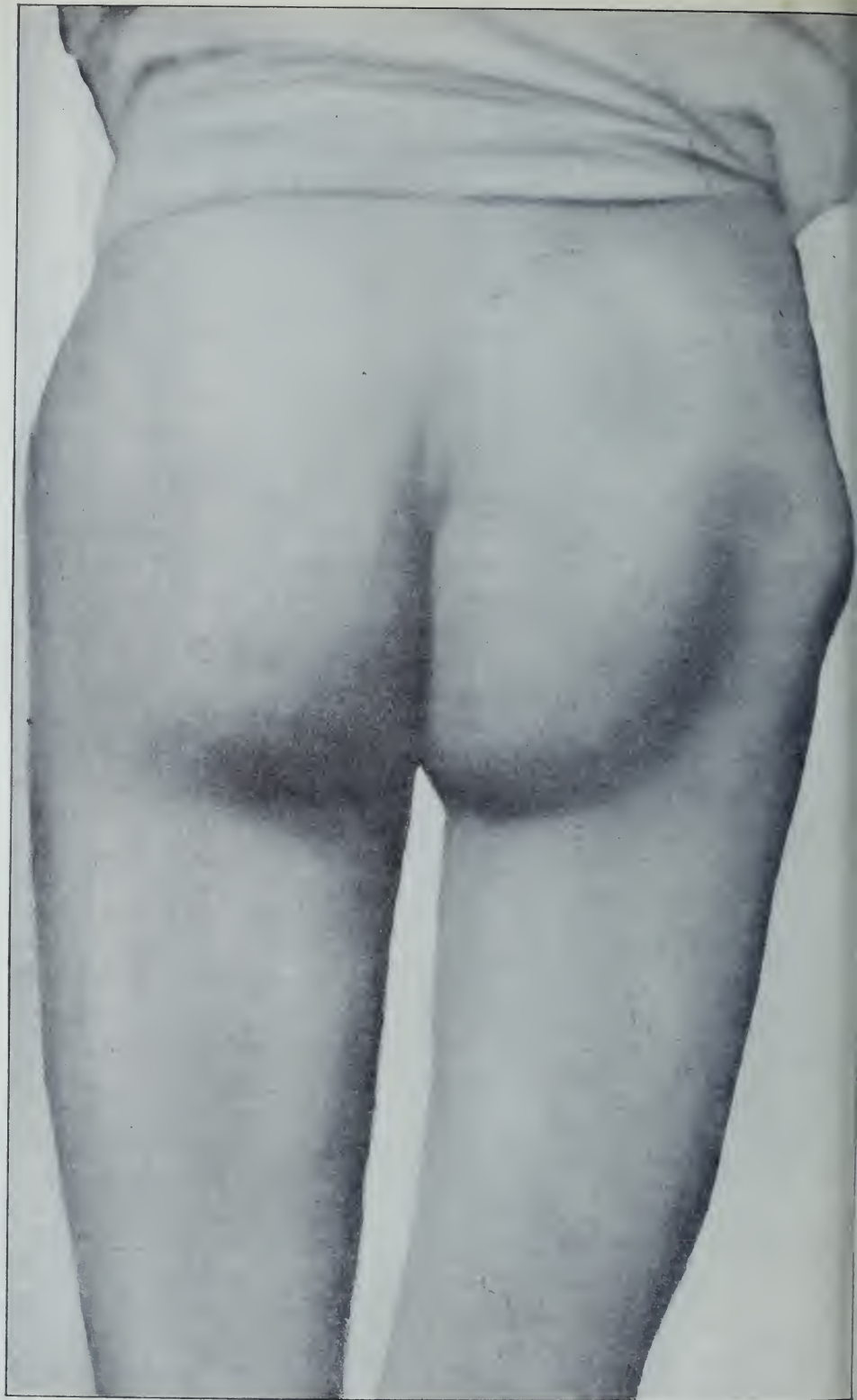


ON COXA VARA.

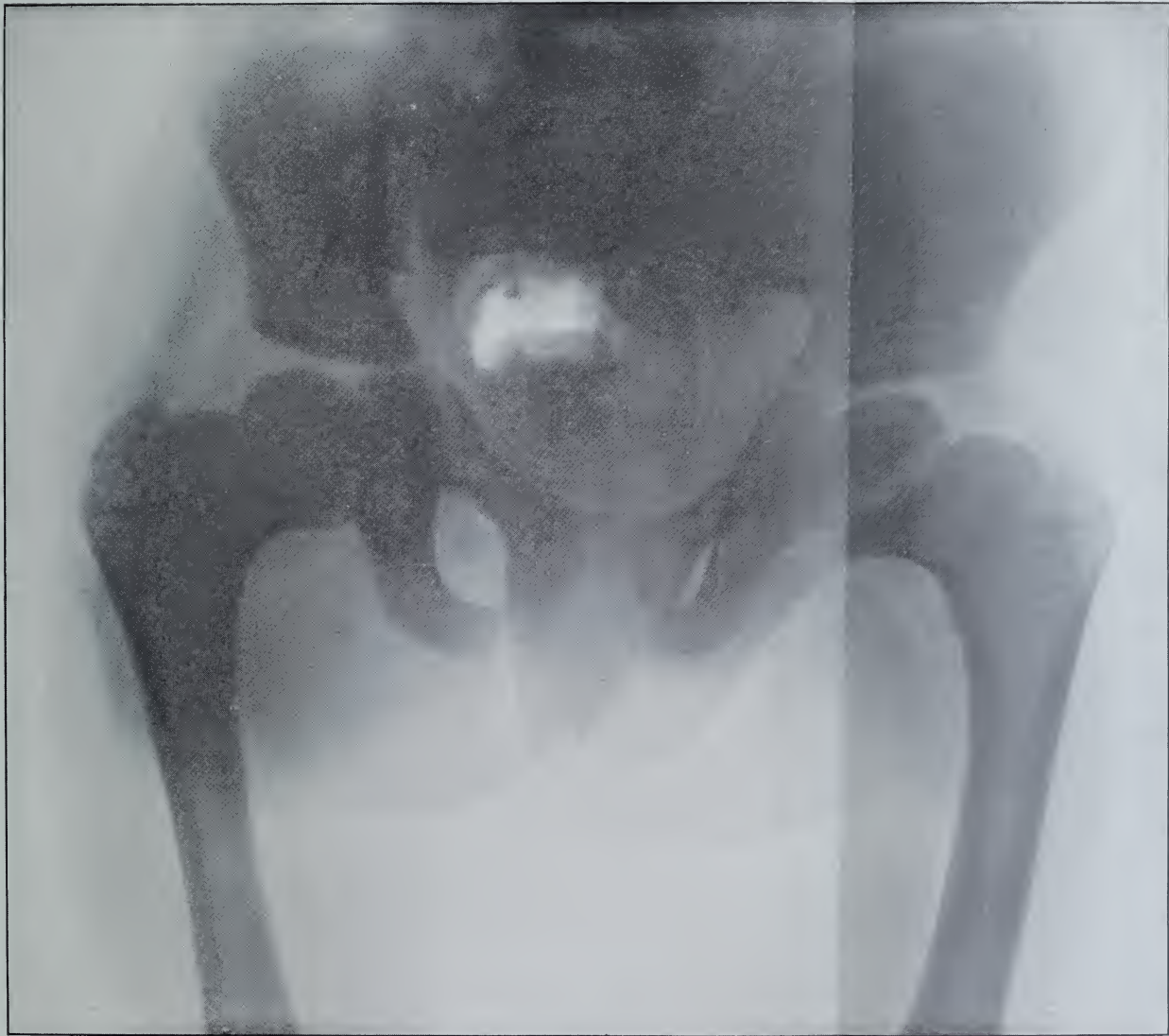
BY JONATHAN HUTCHINSON, F.R.S., LL.D.



Coxa Vara, showing position of the limb. (Dr. Stocker's patient.)



Coxa Vara (Dr. Stocker's patient. See page 528.)



Coxa vara of both hips in a girl of seven years old. The child was rachitic, having the ends of all the long bones enlarged. There was marked genu valgum and twisting of the lower ends of the femora. Head rachitic, ribs beaded. The child walked much as if suffering from congenital dislocation of hips. On each side the great trochanter was an inch above Nelaton's line. Abduction limited. (From a radiograph taken by Dr. David Morgan for Mr. Robert Jones, of Liverpool.)



GENTLEMEN,—As you will, I trust, soon have an opportunity of hearing a lecture on Coxa Vara from Mr. C. Keetley, I shall be very brief in what I have now to say. It is to Mr. Keetley that we owe our first knowledge of this affection, so far as British surgical literature is concerned, and we are also much indebted to him for making us familiar with the writings of Continental authorities.

I do not wish to anticipate Mr. Keetley's lecture, which will come with more authority than anything that I can say. My chief object is to show you some radiographs, which have been kindly lent to me by Mr. Robert Jones, of Liverpool, and with them an excellent photograph of a case of my own. The particulars of this latter case you will find in the November number of the *POLYCLINIC*.¹ The photographic portrait which I now exhibit shows well the position assumed by the limb, the shortening, the eversion, and the projection of the great trochanter. A larger one shows the back view with an apparent widening of the buttock, and a hollow behind the elevated great trochanter. This case, if I mistake not, is one of the most important yet put on record, since it illustrates a complete and uncomplicated case. There was no history of injury, no evidence of rachitis; only one hip was affected, and the disease is traced from beginning to end, the patient having now quite recovered.

No doubt the conditions which it has been agreed to call "Coxa Vara" may be produced under various modes of causation. Rickets is probably the most common, and of this we have a good example in one of Mr. Jones's radiographs. Injuries are the starting point in another group, and rheumatic arthritis in yet another. The younger the patient, and the thicker the disc of unossified cartilage intervening between the head of the bone and what we may call its shoulders or the trochanteric portion of its neck, the more easily are changes set up, and the greater will be the deformity produced. It is obvious to remark that the neck of the femur is of the whole skeleton the part at greatest mechanical disadvantage. It is not in line with the direction of pressure, but transverse to it. If once it begins to yield the yielding is certain to increase. Whether the neck be wholly lost or only changed from the oblique to the horizontal, will depend much upon the age of the patient. Much, perhaps almost everything, will also depend upon whether or not in the early stages the patient is

¹ See page 528.

kept in the recumbent position, or allowed to stand and walk. The early symptoms are usually very slight, and do not appear to necessitate rest. Thus, as in the case recently under our observation, the mischief is often done before the patient seeks advice.¹

ON HEREDITY IN REFERENCE TO XANTHELASMA AND XANTHOMA.

THE cases of Xanthoma which occur in children, or if not in actual childhood, at any rate, seemingly by inheritance, are, as has been already hinted, of great interest in reference to the laws of hereditary transmission.

We may, in the first place, suppose that the offspring inherits from the parent a proneness to disorders of the liver, and that the production of xanthelasma patches on the eyelids is, in the case of offspring, as much secondary to hepatic disturbance as they were in the parent. In favour of this view is the fact that in most examples of xanthelasma of the eyelids in several members of the same family the production of the patches is usually delayed until adult life. Against this is sometimes the statement of those who, in the second generation, show them, that they have been quite free from symptoms of bilious disorder.

We have next the suggestion that, under the law of paryenesis, the structures of the eyelids in offspring are constituted with precisely the same liabilities which those of the parent possessed. Thus, without any liver disturbance or blood disorder, the skin of these special regions tends to undergo changes of the same kind as those which had been manifested in the parent.

A third suggestion is that a xanthelasmic parent may transmit to offspring germ material from the morbid patch capable of gener-

¹ A forthcoming Fasciculus of the New Sydenham Society's Atlas will contain many illustrations of Coxa Vara, and will have the advantage of an introductory essay by Mr. Keetley.

ating its like. This would bring the process into line with what we suppose to take place, at any rate, in some of the instances of the hereditary transmission of cancer and new growths. There are many reasons for believing that both in xanthelasma and xanthoma the new material may possess infective qualities. The patches of the former almost always advance at their borders, and in the eruptive form of xanthoma it is impossible not to believe that infective germs are distributed by the blood. Now some of the examples of these affections in young children would appear to require both these two latter hypotheses for their explanation. They deviate a good deal from all the types of the malady met with in adults. In Sir Thomas Barlow's case a child had xanthelasma patches on the eyelids, but they were not in quite the usual positions, and there were others on the upper arm near the vaccination scars—a position very unusual in adults. In one of the cases described in our Museum List the child had patches on the eyelids, and some also scattered irregularly on the back. Nor did the patches reproduce exactly those of either xanthelasma or xanthoma. Similar remarks apply to Dr. Barr's case, and also to a case which has come under observation whilst these pages were passing through the press, in which a girl, whose eruption began in infancy, shows symmetrically grouped spots on the cheeks much like adenoma sebaceum, but arranged on the eyelids just like those of xanthelasma. In all these cases the suggestion that some infective material was taken over by the child offers the most plausible explanation of the phenomena. This group of cases is of great interest, and must receive further investigation. It is not to be expected in a disease so easily overlooked as xanthelasma of the eyelids, and so transitory as xanthoma diabeticorum, that the history of the affection in progenitors will often be known to the patient or even to the child's parents. Atavism is probably of frequent occurrence, and we can but seldom expect to find evidence of inheritance further than the existence of the disease itself implies. In a few cases, however, the history has been forthcoming.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY JAMES TAYLOR, M.D., F.R.C.P.

Tuesday, November 4, 1902.

Hemiplegia after Tonsillitis.

THE case was that of a young woman, who, five years ago, suddenly developed right hemiplegia and aphasia during an attack of tonsillitis. In discussing the pathology of the case, Dr. Taylor said there were two possible views, viz., (1) that the hemiplegia was due to embolism, the tonsillitis being presumably rheumatic and possibly attended with endocarditis; and (2) that the cause of the hemiplegia was an intracranial thrombosis. Had the paralysis been of a different distribution, and not attended by aphasia, it might, perhaps, have been held that the affection of the throat was diphtheritic, and the paralysis a sequel of diphtheria. In the present circumstances, however, such a diagnosis need hardly be discussed. An instructive feature of the case was the extent to which recovery had been attained. Though originally completely paralysed on the right side, and speechless, the patient can now walk with only a moderate defect, and her speech, though not prompt, and liable at times to confusion, is relatively efficient. Such a measure of improvement is not uncommon in hemiplegia dependent on intracranial embolism, and the same is true of thrombosis. It is reasonable here to conclude that the improvement will probably continue to a still more perfect level.

Cretinism and Thyroid Extract.

Dr. Taylor showed a bright active girl of 14 years who had been under his observation since she was $4\frac{1}{2}$ years of age. At that

time she had all the physical and mental characteristics of a cretin, and her present condition is due to the fact that she has been treated continuously with thyroid extract. She is now, and has been for some years, in vigorous physical health, and her mental state, though somewhat juvenile for her years, is one of active intelligence. The case, therefore, illustrates in a very striking fashion the value of thyroid extract in the treatment of cretinism, provided that is, that the remedy is continued. In the present case an attempt was made some years ago to suspend the use of the thyroid, but the patient promptly showed signs of relapse. A noteworthy point was the fact that when first seen she had no teeth and that these appeared in the course of a few weeks after thyroid treatment was commenced.

A Case of Achondroplasia.

This child was a good example of the rare condition named achondroplasia, which was described and illustrated in our March number (page 120). In addition to the shortness of the limbs and the peculiar shape of the skull, the patient showed the usual gap between the middle and ring fingers and a marked depression at the root of the nose. Attention was also drawn to the weight of the child. When lifting her from the ground, it was astonishing to find that so small a child could be so heavy.

Other patients included (1) a case of Friedreich's ataxia; (2) an example of optic neuritis from cerebral tumour; and (3) a patient with chronic gastritis, probably due to alcohol.

BY SIR WILLIAM H. BROADBENT, BART.

Tuesday, November 18, 1902.

A Series of Cardiac Cases.

THE first patient, a woman of 60 years, illustrated some of the effects which may be produced on the heart and circulation by chronic bronchitis and pulmonary emphysema. In the first place there was observed conspicuous pulsation in the upper part of the epigastrium, and the hand readily appreciated this as due to the

rhythmical action of the right ventricle. Further evidence of the downward displacement of the heart by the over-expanded lungs was found on percussion, which gave resonance instead of dulness over the whole præcordial area. In addition, there was proof of the strain which the pulmonary condition had inflicted on the right ventricle, for over the lower sternum was a systolic murmur indicative of tricuspid regurgitation—the valvular orifice having yielded as part of a general dilatation of the ventricular cavity. Sir William Broadbent drew attention to the fact that with these signs of displacement and dilatation of the heart there existed a pulse of high tension. He explained this as the result of imperfect aëration of the blood. Such a condition means the retention of waste matters in the blood, and these—just as in the defective elimination which attends chronic kidney disease—irritate the walls of the vessels and therefore cause contraction of the arterioles and rise of blood-pressure. One consequence of this undue arterial tension may be—and it was illustrated in the case under discussion—a “spacing” of the heart sounds. The ventricular systole, as a result of the increased peripheral resistance, is prolonged, so that there is an abnormally long interval between the first and the second sound, with a corresponding abbreviation of the interval between the second sound and the next first sound. That is, the cardiac rhythm is altered from 1, 2, silence ; 1, 2, silence ; to 1 and 2 and ; 1 and 2 and ; or, to define the position in other words, the interval between the first and second sounds is about the same length as that between the second and first. This fact is of some prognostic value. It indicates that in spite of abnormal resistance the ventricles are succeeding in emptying themselves, and that they are, so far, efficient as agents for propelling the blood into the arteries. Return of the cardiac sounds to a normal rhythm has, in a patient with advanced emphysema, an opposite and less favourable significance. Obviously it cannot in the circumstances mean restoration of the healthy balance of the circulation. It rather shows that the ventricular systole is short and imperfect, that the cavity of the ventricle does not become completely emptied, and it must, therefore, be taken to suggest the approach of the results of backward pressure on the venous channels in the shape of dropsies and passive congestions of various organs and tissues.

In a second patient, also a woman of 60 years, the primary

fact appeared to have been considerable and widely spread degeneration in the systemic arteries, and the examination offered an opportunity to study the effects which such degeneration may produce on the heart. In the first place it was obvious that there was considerable hypertrophy of the left ventricle, the left border of dulness and the cardiac impulse being both displaced to the left, and the latter having a strong thrusting character. At a limited area in the neighbourhood of the impulse the first sound came under suspicion in reference to the existence of a systolic murmur, but the most interesting auscultatory fact was the discovery of a short diastolic murmur heard in the region of the apex, but at no other part of the præcordium. In discussing the significance of this murmur, Sir William Broadbent said that a short diastolic murmur limited to the apex region was sometimes due to a dilatation of the first part of the aorta, the cusps of the aortic valve, though healthy, failing in such circumstances to close the orifice, and thus permitting some measure of regurgitation. Support for the application of this explanation to the present case was found in (1), the existence of arterial degeneration as presumptive evidence of atheroma in the large vessels; (2), the fact that the second sound was heard more loudly an inch or more to the right of the sternum than over the aortic cartilage—a circumstance tending to show an alteration in the position of the valve in reference to the surface anatomy; and (3), an unusually loud breath sound over the manubrium, to be explained probably as the result of a dilated aorta impinging on the trachea behind and the sternum in front and thus securing an exceptionally favourable mechanism for the transmission of the tracheal sound.

A third patient was a woman of 27 years, in whom murmurs (systolic) were recognised as produced at all the four valvular orifices of the heart. Such a combination, it was pointed out, indicated almost certainly functional, and not organic disturbance. Hence a favourable prognosis was given, and rest and tonic treatment prescribed.

The Treatment of Pernicious Anæmia.

In a case of pernicious anæmia, Sir William Broadbent advised that arsenic should be pushed, the dose, unless the remedy disagreed,

to be gradually increased to 15 minims of Fowler's solution thrice daily. In addition, the patient was ordered to take raw meat juice. The value of dried arterial blood in such cases was also emphasised, and it was explained that the therapeutic efficacy of the substance depends on the presence of the various internal secretions of the animal economy, and is not due to hæmoglobin. In even extreme cases of the disease, the injection of defibrinated blood into the bowel may produce temporary improvement.

The other cases included (1) a woman the subject of intracranial disease ; and (2) a young man convalescent from tubercular pleurisy.

DISEASES OF THE EYE.

BY R. MARCUS GUNN, F.R.C.S.

Friday, November 14, 1902.

A Case of Interstitial Keratitis.

THE chief features of interest in this case were (1), the comparatively late age at which the disease occurred, and (2), the length of the interval which elapsed before the second eye was attacked. As contrasted with the usual incidence of the affection in childhood or early adult life, the present patient was 36 years of age before she began to suffer from irritation and dimness of vision in the right eye, found on examination to depend on the existence of interstitial keratitis. Under treatment recovery was complete, and the patient remained without cause of complaint for five years, when a condition similar to that which first appeared in the right eye developed in the left eye. In children the disease usually attacks both eyes at or about the same time, but in adults the affection of the second eye is not infrequently postponed for several months, or even longer. An interval of five years is an unusual but by no means an unprecedented one. The condition of the right cornea was an illustration of the completeness of the recovery which usually attends interstitial keratitis. In speaking of the treatment of the case, Mr. Gunn emphasised the importance of local measures in the form of atropine and hot fomentations. Children, particularly, need

good nourishment and fresh air, the eyes being protected by the use of dark glasses; when there are evidences of struma, tonics such as syrup of iodide of iron, and cod liver oil are indicated. Anti-syphilitic remedies are of less certain value, but small doses of grey powder may possibly do good in some cases. When redness and other signs of irritation have disappeared, a weak ointment of yellow oxide of mercury applied with gentle massage through the closed lids will assist in the removal of the opacity of the cornea.

A Case of Phlyctenular Ophthalmia.

The patient, a boy of 5 years, was the subject of a small central corneal ulcer, the result of a phlyctenular keratitis. Mr. Gunn drew attention to the existence of large glands in the neck and remarked on the frequency with which strumous children suffer from phlyctenular disease, and on the tendency of the affection to recur. Though usually situated at the corneal margin, phlyctenules may form on any part of the conjunctiva. Thus, as here, the phlyctenule may give rise to a central corneal ulcer, whilst in other cases it appears on the sclerotic at some distance from the cornea. In these latter it may attain relatively large proportions (pustular ophthalmia) and is usually attended with but slight evidences of irritation. In a child predisposed to the formation of phlyctenules any irritation, *e.g.*, that due to a foreign body, may excite their appearance. Hence the importance of checking irritation in such patients at the earliest possible moment, and of resting the eyes for a few days after removal of a foreign body. Another possible association of phlyctenular ophthalmia is with interstitial keratitis. In a child the subject of hereditary syphilis, the occurrence of phlyctenular disease is apt to lead to the development of interstitial keratitis. The treatment of such patients, therefore, when the subjects of phlyctenular conjunctivitis, must be particularly careful. A prolonged rest and the use of dark glasses should be enforced. Speaking on the general subject, Mr. Gunn advised against the use of yellow ointment except at the very onset, before the development of signs of irritation, or later, when all photophobia and lachrymation have ceased, or again, when the phlyctenule is situated over the sclerotic. During the active stage the proper measures are hot fomentations and the instillation of atropine.

Case of Toxic Amblyopia.

The patient was a man of 35 years, who, three months ago, began to complain of dimness of vision affecting both eyes, his sight being better in a dim than in a bright light. The usual tests showed a reduction of the visual acuity to $\frac{6}{60}$, whilst of the near types the patient could not read below J 18. The ophthalmoscope failed to explain these defects; the visual fields were full; and there was no evidence of central nervous disease. It was possible, however, to detect a small central scotoma both for red and green. The patient admitted that he smoked half an ounce of medium tobacco daily; alcohol he used only in moderate quantities. After giving up tobacco for a month his sight had not improved, but since then a considerable measure of sight had been regained. Mr. Gunn drew attention to the fact that the symptoms in this case, and more especially the presence of a central colour scotoma—green being a more delicate test for this than red—at once suggested, in the absence of diabetes mellitus, tobacco poisoning. Occasionally such a condition is found apart from tobacco and in several members of the same family. This is known as Leber's disease, and the prognosis is a very bad one. In tobacco poisoning, on the other hand, the prognosis is good provided the patient will strictly abstain from both alcohol and tobacco. Improvement, however, must not be expected in less than six to eight weeks. In rare cases it is still further delayed, and Mr. Gunn quoted an instance in which the patient had only recovered perfect vision at the expiry of two years after he first came under observation. The patients, more especially when improvement is long delayed, are naturally apt to become despondent, and it is of great importance that they should be encouraged to take a cheerful view of their prospects. This probably increases the chance of recovery and is a counterpart to the fact that grief or mental strain is often found to be the immediate precursor of the failure of sight.

DISEASES OF THE EAR.

BY W. JOBSON HORNE, M.D., B.C., M.R.C.P.

*Friday, October 17, 1902.**The Treatment of Chronic Suppuration in the Middle Ear.*

IN speaking on the subject of chronic suppuration of the middle ear, in connection with several cases illustrating this condition, Dr. Jobson Horne described the general plan of treatment which it is advisable to follow in a patient who has for several months been the subject of a purulent discharge from the tympanic cavity. The first demand, he said, was for thorough and vigorous cleansing, and this can scarcely be secured except by the personal attention of the surgeon. Nothing for this purpose is better than a solution of carbolic acid. It both overcomes the obstacle provided by greasy secretions and possesses the penetrating property necessary to secure efficient contact with the diseased surfaces. A solution of the acid—1 in 20—diluted at the time of application with an equal volume of hot water, is a strength suitable for the patient to employ, and the ear should be syringed with this fluid several times daily for two days. The next step is to carefully pack the ear with strips of gauze soaked in a solution containing 5 per cent. of carbolic acid and one fifth per cent. of perchloride of mercury. This should be repeated twice daily for about a week, by which time the discharge will almost certainly have decidedly lessened and perhaps altogether ceased. In judging of the latter event the decision must not be taken by such a rough criterion as the presence or absence of pus in the external meatus. Small pledgets of wool must be carefully introduced, and it must be observed whether or not these acquire a purulent stain. If this test, repeated daily for two or three days, gives a negative result, the patient need not be seen again for a fortnight, and if the condition is then equally satisfactory there is no immediate need for further interference. On the other hand, should the measures above described fail to stop the discharge of pus, it is probable that the dead bone which is present must be removed, in accordance with general

surgical principles. Either the ossicles themselves may be carious, in which case ossiculectomy should be performed, or carious bone may exist in the region of the mastoid antrum, and must be removed. The operation is to be followed by packing the ear with carbolic and perchloride gauze. If, in spite of all these measures, the discharge still continues, it is a fairly confident conclusion that the disease can only be successfully met by a radical operation, and this must be sufficiently thorough to completely open the cavity of the antrum into that of the middle ear. This operation will certainly remove the patient from the area of danger, so far as intracranial risk is concerned, though it will hardly improve his hearing, and, in some cases, does not entirely get rid of the discharge.

Ear Disease and Life Insurance.

The recognition of the deterioration of the general health as well as of the definite risk of intracranial complications which attends suppurative disease of the middle ear has made diseases of the ear a practical issue in the question of life insurance. Each case must be judged on its individual merits, and to apportion the exact risk is not always easy; but the following general rules may be taken as guiding principles:—

(I.) Diseases of the External Ear—the auricle and external meatus—may be dismissed as having *per se* no practical bearing on life insurance, with a single possible exception. This exception is provided by the presence of bony growths—exostoses—arising from the wall of the meatus. In themselves, of course, these tumours are not sources of danger. But they are not infrequently associated with the existence of suppuration in the deeper parts of the auditory apparatus, and by their bulk and situation they may readily conceal such suppuration from ready scrutiny. Hence they call for a particularly thorough examination, and only when this gives a satisfactory result should the applicant be accepted as a first-class life.

(II.) Diseases of the Middle Ear frequently have an important bearing on Life insurance, more especially those of the chronic suppurative order. An acute inflammation attended with serous or sero-purulent discharge calls for no more serious measure than postponement of the proposal until the applicant is cured. Chronic suppuration, on the contrary, either as an existing fact or as a point in

the applicant's history, always demands careful attention. In connection with this question there is usually an opportunity for estimating—apart from the clinical possibilities of the disease—an element in the personal bearing of the applicant which is not unimportant in deciding the issue. Almost invariably the affection has been in existence for a considerable period—often many years—before the question of Life insurance has been raised, and the physician thus has the chance to determine whether the applicant is a person disposed to attend to his own well-being or to be careless regarding risks to his health. And this is a factor which ought to receive due consideration. For, obviously, the dangers in the one case are much less than in the other even when the character of the lesion is the same in each.

The various possible cases may be grouped as follows :—

(1) When there is no existing discharge, but merely healthy scar tissue the result of an exhausted inflammation, the life may be accepted at ordinary rates.

(2) When there is no discharge, but a perforation of the tympanic membrane exists, the situation of the perforation is a large element in the decision. A dry clean-edged perforation, even though of some considerable size, in the membrane proper is no bar to life insurance and does not call for a loaded premium. But a perforation in Shrapnell's membrane raises an entirely different question. Such a perforation means that the disease involves the tympanic attic, with a greater difficulty in the escape of pus, a much less probability of thorough and successful treatment, more risk of bone disease, and the added chance of intracranial complications. In these circumstances the proposal, if accepted at all, should have attached to it an increased premium.

(3) When with chronic middle ear disease there is, on the same side, facial paralysis (Bell's palsy), the proposal should be refused, as such a state of matters means sufficient bone disease to introduce a definite risk of intracranial mischief, and this certainly lessens the chance of the applicant realising the expectation of life natural for his age.

(4) When chronic suppurative disease is attended with headaches and attacks of vertigo the life should be refused and the applicant advised to submit to a radical mastoid operation.

(5) Chronic non-suppurative disease, unless attended by extreme deafness, hardly affects a proposal for life insurance. With a high degree of deafness there is necessarily an increased risk of accident or injury, and this in certain occupations might be considerable.

In all cases due weight must be given to general considerations. The disposition of the applicant to take care of or to disregard his health, his occupation, his place of residence, his situation in reference to efficient treatment—these and other circumstances must have a share—and in some cases it is an important share—in framing the final decision.

DISEASES OF THE NOSE AND THROAT.

BY HERBERT TILLEY, M.D., F.R.C.S.

Friday, November 7, 1902.

Hypertrophic Rhinitis in a Boy.

THE patient, a boy aged 6 years, was sent for consultation on September 26, when it was seen that he was suffering from almost complete nasal obstruction, coupled with a constant discharge of thick, clear mucus from both nostrils. Enlarged tonsils and adenoids had been removed without curing the nasal trouble, which had also remained uninfluenced by tonics, such as iodide of iron, cod-liver oil, arsenic, etc.

On Nov. 4, under chloroform, the greater portion of each inferior turbinal was removed by means of the turbinotome, the mode of using which was demonstrated, as also were the specimens of hypertrophied mucous membrane and bone which had been removed. The patient could now breathe quite freely, and the nasal discharge had practically ceased. While the milder cases of hypertrophic rhinitis can be much benefited by the daily use, for a few weeks, of an alkaline nasal douche and by attention to the general health, it was pointed out that even in the worst cases complete removal of the inferior turbinals was rarely, if ever necessary either in children or adults. In the present case it was really

only the lower half of each bone that had been removed, and in the course of a few months much of the lost tissue will probably be replaced by healthy and less redundant tissue. The danger of secondary hæmorrhage in complete turbinectomy is a risk to be remembered—it has not infrequently occurred and has often entailed serious loss of blood.

In adults suffering from the severer forms of hypertrophic rhinitis not capable of cure by the galvano-cautery, perfect relief from the nasal obstruction can be obtained by removal of the anterior half of the inferior turbinal bone, coupled, if necessary, with removal of the hypertrophied mucous membrane of the posterior half by means of a wire snare. [The methods of performing these operations were described.] A warning against complete turbinectomy is necessary, for in some patients where this operation has been carried out, the loss of so much physiological mucous membrane has engendered a troublesome form of dry throat, which has been a greater evil than the symptoms for which the operation was undertaken.

Bilateral Abscess of the Nasal Septum.

A lad, aged 17, was shown, illustrating this condition. He had received a blow on the nose while boxing; this had been followed by slight epistaxis, and in the course of a few days the nose became red and painful, while nasal respiration gradually became impossible.

On admission to the hospital both nostrils were seen to be occluded by a red, smooth, elastic and painful swelling, which was obviously attached to the septum. The swelling on the right side was anæsthetised with cocaine and then incised, giving rise to a free discharge of yellow, non-fœtid pus. Both swellings emptied themselves through the one incision, showing that they communicated through the septum. Lightly packing the nostril with antiseptic dressings until the inflammation has subsided is the only after-treatment required.

Abscess of the septum[•] is nearly always the result of traumatism, and presumably the septic organisms gain entry through some abrasion in the mucous membrane. The extreme redness of the nose might suggest erysipelas, but the appearances in the nostrils should render the diagnosis clear. Incision, with antiseptic precautions, is the only treatment required.

*Chronic Suppuration of the Left Frontal Sinus ; Radical Operation ;
Permanent Cure.*

Patient was a female, aged 39 years. The operation was performed to relieve chronic headache, which had resisted all milder measures. The case showed how little deformity might result even when the sinus was totally obliterated. The surgeon should, however, be particularly careful always to clearly point out to the patient, especially if a female, that it is absolutely impossible to say before the operation what the size of the resulting scar will be. A small person may have a very large sinus, and *vice versa*. Possibly it may be found feasible to improve the depressed scar in some of these cases by the subcutaneous injection of paraffin.

Transillumination of this patient's left antrum showed it to be darker than on the right side, and yet there had been no pus in it for two years. This opacity is due to a thickening of the bone, because it may be noticed a week after a radical operation when the mucous membrane has not had sufficient time to re-form.

Another case was shown illustrating the effect of trans-illumination in a healthy person, and the importance of the infra-orbital crescent of light was dwelt upon. Absence of the "light-crescent" on each side proves nothing, but the presence of opacity on one side and a well-marked infra-orbital "light-crescent" on the other is a very valuable help in the diagnosis of affections of the maxillary sinus.

CORRESPONDENCE AND ANSWERS.

STILL-A-LEARNER asks us as to the meaning of certain more or less new words. We have pleasure in doing our best to assist him.

Meralgia paræsthetica (μυρὸς the thigh) is a name given by Dr. Roth, of Moscow, to an affection of the region of the thigh supplied by the external cutaneous nerve. It is not infrequent in tabes and other diseases of the nervous system, but frequently stands alone. It is possibly sometimes an arsenical neuritis.

Acro-melalgia.—The word *melalgia* signifies limb-pain, or pain in the limbs, and the addition of *acro* denotes that the pain occurs in the very ends of the limbs, that is, in the pulps of the digits. If, in addition to the subjective phenomenon of pain, there is objective congestion, then the term erythro-melalgia becomes applicable.

Erythro-melalgia.—A term applied to conditions in which the digits and chiefly their extremities become red and painful, with, usually, desquamation of epidermis. It is a neurotic affection.

Angina ludovici.—Inflammation, more or less acute, of the cellular tissue of the neck. The glands may be implicated. It may be caused, and probably usually is so, by infection received from the tonsils or pharynx. It is, perhaps, a form of phlegmonous erysipelas. Mr. Mandeville, the Irish political prisoner, died of it.

* * *

LADIES and children are excusable when they forget that two individuals are requisite to parentage, and express surprise that some of their kittens are very different from the mother cat. We expect men to be more wideawake, and as a rule they are so. It is very remarkable, however, how frequently in statements as to hereditary tendencies this simple fact escapes recognition. An instance of this has just come under our notice in a biography of Toussaint L'Ouverture. In the course of an address, the speaker, Mr. Wendell Phillips, an abolitionist and negro-advocate, said "He had been born a slave . . . an unmixed negro—his father stolen from Africa. If anything, therefore, that I say of him to-night moves your admiration, remember the black race claims it all, we have no part nor lot in it." No word is vouchsafed as to Toussaint's mother, who, in all human probability, was a mulatto.

* * *

LOSS OF SENSATION IN LEPROSY.—Dr. Macrae, in a paper published in the *Medical Times and Gazette* for July, 1875, had some important observations of the difference between the loss of sense of touch and that of pain in leprosy. His observations were made in Madras. He found it much easier to mark out areas of loss of sense of pain than of that of touch, and very often the two were not lost together. Touch sensation was often lost when pain sensation was retained; as a rule the areas not sensitive to pain were also insensitive to temperature. The areas of loss of sensation were usually placed with symmetry.

We are indebted to Dr. Alfred Gubb for drawing our attention to the following. It appears in *La Semaine Médicale* for December 10 ult. :—

“CANCER ARSENICAL.

“M. J. Darier.—Voici un homme de quarante sept ans que j’ai eu l’occasion d’examiner une première fois en 1890. A cette époque il présentait sur la face et le cou un semis confluent de taches pigmentaires lenticulaires et de macules vasculaires. Les mains et les pieds étaient le siège d’une hyperkératose diffuse avec d’innombrables verrucosités cornées. Je l’avais perdu de vue depuis douze ans, lorsqu’il est revenu me voir au printemps dernier. J’ai alors pu constater que la mélanodermie et les télangiectasies s’étaient atténuées, mais que les verrues cornées persistaient. Quatre d’entre elles, trois aux mains et une au cou, s’étaient transformées en véritables épithéliomes; ce diagnostic fut vérifié par l’examen histologique pratiqué après que ces petites tumeurs eurent été enlevées à la curette. Actuellement, on voit à l’angle de l’un des yeux se développer un nouvel épithéliome. Or, l’origine de ces lésions cutanées trouve son explication dans ce fait que le malade, pour traiter une bronchite chronique avec induration des sommets, a pris quotidiennement, de 1886 à 1896, 12 gouttes de liqueur de Fowler pendant douze jours chaque mois et, depuis 1896 jusqu’en 1901, durante sept jours par mois.

“On sait qu’en 1887, M. J. Hutchinson soutint l’existence d’un cancer arsenical (Voir *Semaine Médicale*, 1887, p. 502-503). Cette opinion, accueillie à l’époque avec scepticisme, a été confirmée depuis lors par un petit nombre d’observations. Le cas actuel nous semble lui apporter un appui sérieux.”

* * *

A CARBOLIC ACID BATH.—M. L., who suffered from old psoriasis and an arsenical skin, derived great benefit from a carbolic acid bath. He used an ounce of carbolic to five gallons of warm water, either as a sitz or sponge bath. His experience was that it softened the skin. He said that it gave him palpitation and might keep him awake at night; its effect in this respect was exactly like that of strong tea. He was accustomed to sit in it half-an-hour, and to sponge his face and other parts fully. He soaks his hands but not his feet. He used to take it at one o’clock every day, but latterly he has reduced the strength to half an ounce, and takes it only twice a week instead of daily.

* * *

YOUNG birch trees are at the present time yellow with abundance of the teleutospores of a uredo (*Melampsora betulina*). It develops chiefly in the lower branches of trees not more than three or four feet high and is rarely to be seen on old trees.

Young maple trees, or the young and vigorous shoots from old stools, are affected in like manner by an erysiphe (*E. vicornis*). They are white over with the growth of this form of mildew as if covered with hoar frost. The older trees escape.

It is to be noted that neither the mildew nor the uredo are in any association with dampness of the locality. They are found on uplands well exposed to both sun and wind.

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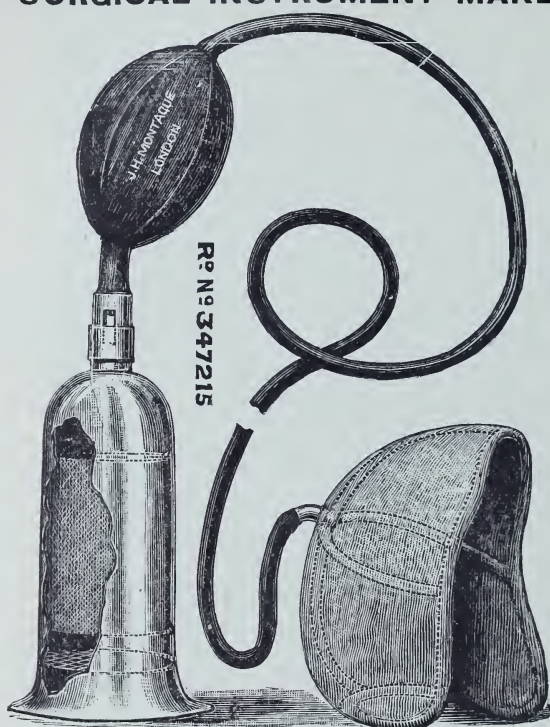
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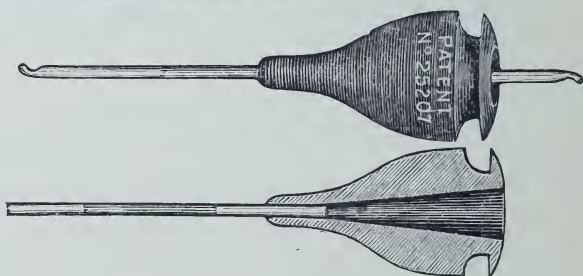
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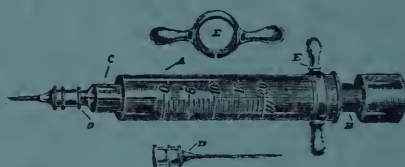
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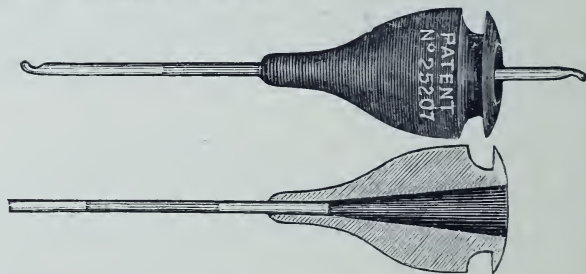
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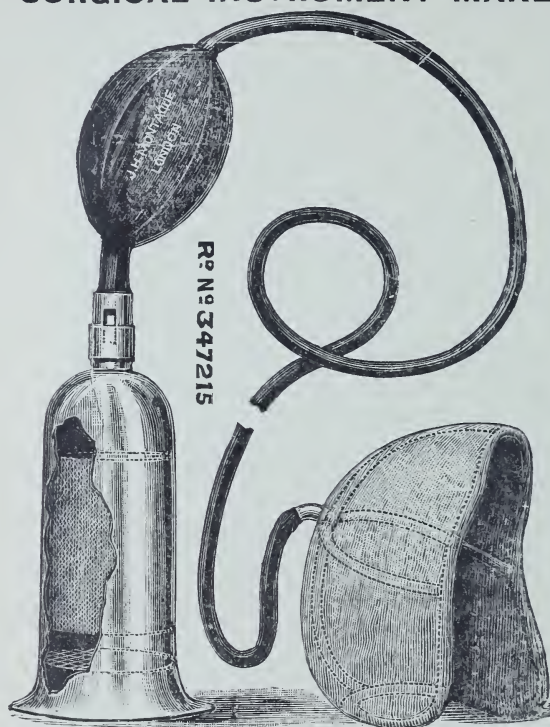
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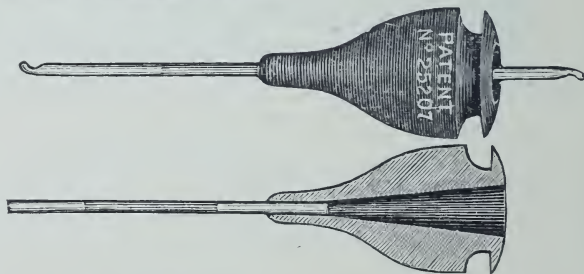
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From **JANUARY** to **MARCH 1902.**

Cliniques at 4 p.m.

MONDAYS. (Skin)	TUESDAYS. (Medical)	WEDNESDAYS. (Surgical)	THURSDAYS. (Surgical)	FRIDAYS. (Eye, Ear, Nose, and Throat.)
		January 1 New Year's Day.	January 2 College Opens.	January 3 Dr. H. Tilley
January 6 Dr. T. Colcott Fox	January 7 Dr. Harry Campbell	January 8 Mr. J. Cantlie	January 9 Mr. W. H. A. Jacobson	January 10 Mr. R. Lake
January 13 Dr. J. Galloway	January 14 Dr. Seymour Taylor	January 15 Mr. P. J. Freyer	January 16 Mr. W. H. A. Jacobson	January 17 Mr. Marcus Gunn
January 20 Dr. J. J. Pringle	January 21 Sir W. H. Broadbent	January 22 Mr. R. Harrison	January 23 Mr. J. Hutchinson, Jrnr.	January 24 Dr. St. Clair Thomson
January 27 Dr. Graham Little	January 28 Dr. James Taylor	January 29 Mr. J. Berry	January 30 Mr. J. Hutchinson, Jrnr.	January 31 Dr. Dundas Grant
February 3 Dr. J. F. Payne	February 4 Dr. W. Ewart	February 5 Mr. A. H. Tubby	February 6 Mr. W. H. A. Jacobson	February 7 Mr. Ernest Clarke
February 10 Dr. A. Whitfield	February 11 Dr. C. Theo. Williams	February 12 Mr. J. Cantlie	February 13 Mr. W. H. A. Jacobson	February 14 Dr. H. Tilley
February 17 Dr. T. Colcott Fox	February 18 Dr. R. L. Bowles	February 19 Mr. A. H. Tubby	February 20 Mr. W. H. A. Jacobson	February 21 Dr. Dundas Grant
February 24 Dr. J. Galloway	February 25 Sir W. H. Broadbent	February 26 Mr. Johnson Smith	February 27 Mr. W. H. A. Jacobson	February 28 Mr. Work Dodd
March 3 Dr. Radcliffe Crocker	March 4 Dr. J. E. Squire	March 5 Mr. Howard Marsh	March 6 Mr. Hutchinson	March 7 Dr. Jobson Horne
March 10 Dr. J. J. Pringle	March 11 Dr. W. Ewart	March 12 Mr. E. W. Roughton	March 13 Mr. Hutchinson	March 14 Mr. R. Lake
March 17 Dr. J. F. Payne	March 18 Dr. Guthrie Rankin	March 19 Mr. J. Berry	March 20 Mr. Hutchinson	March 21 Mr. Treacher Collins
March 24 Dr. T. Colcott Fox	March 25 Dr. C. Theo. Williams	March 26 Mr. Jackson Clarke	March 27 Mr. Hutchinson	

Clinical Lectures at 5.15 p.m.

Jan. 15th.—J. HALLIDAY CROOM, Esq., M.D., F.R.C.S., of Edinburgh.
 Jan. 29th.—HENRY POWER, Esq., F.R.C.S.
 Feb. 12th.—T. CLAYE SHAW, Esq., M.D., F.R.C.P.
 Feb. 26th.—RUSHTON PARKER, Esq., F.R.C.P., of Liverpool.
 March 12th.—M. HANDFIELD JONES, Esq., M.D., F.R.C.P.
 March 19th.—C. A. MORTON, Esq., F.R.C.S., of Bristol.

Special Courses of Lectures at 5.15 p.m.

Jan. 20th, 27th, Feb. 3rd.—MR. HAYWARD PINCH, "The Examination of the Urine."
 Jan. 24th, 31st, Feb. 7th.—MR. R. LAKE, "Laryngeal Tuberculosis."
 Feb. 10th, 17th, 24th.—MR. E. W. ROUGHTON, "Some Surgical Affections of the Mouth and Neighbouring Parts."
 Feb. 14th, 21st, 28th.—DR. T. N. KELYNACK, "Tumours of the Kidney."
 March 14th, 21st, 28th.—MR. SYDNEY STEPHENSON, "The Commoner Diseases of the Eye in Children."
 March 17th, 24th, 31st.—MR. C. B. KEETLEY, "The Management of Complicated Fractures."

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Clinical Examination of the Nervous System	{	James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P.
Practical Ophthalmology: the use of the Ophthalmoscope and Refraction	{	L. V. Cargill, F.R.C.S.
Practical Otology	{	J. Dundas Grant, M.D., F.R.C.S. Richd. Lake, F.R.C.S.
Practical Rhinology and Laryngology	{	St. Clair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.D., M.R.C.P.
The Application of the Röntgen Rays		F. Harrison Low, M.B.
Clinical Microscopy		A. E. Hayward Pinch, F.R.C.S.

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Practical Bacteriology	R. Tanner Hewlett, M.D., M.R.C.P.
Mental Diseases	Maurice Craig, M.D., M.R.C.P.
Hygiene and Public Health	A. Wynter Blyth, M.R.C.S., F.C.S.
Operative Surgery	W. Johnson Smith, F.R.C.S.

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The Easter Term of practical classes commences on Monday, April 14.

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The Anatomy and Physical Diagnosis of the Chest and Abdomen. Tuesdays and Thursdays, at 6 P.M., commences April 14. Dr. J. E. Squire and Mr. A. Carless.

Clinical Examination of the Nervous System. Fridays, 2 to 3.30 P.M., commences April 18. Dr. Harry Campbell.

Practical Application of Röntgen Rays. Thursdays, 3 P.M., commences April 17. Dr. Harrison Low.

Practical Ophthalmology: the Use of the Ophthalmoscope and Refraction. Fridays, 5 to 7 P.M., commences April 18. Mr. L. Vernon Cargill.

Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M., commences April 16. Dr. W. Jobson Horne.

Practical Otology. Mondays, 5 to 7 P.M., commences April 14. Mr. R. Lake.

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Nerves.—Spinal Accessory, Musculo-spiral, Sciatic.

SECOND DAY.—*Head and Neck.*

Trephining Operations.—Middle Meningeal Artery, Lateral Sinus, Mastoid Antrum, Frontal Sinus.

Removal of Eyeball, (Esophagotomy, Laryngectomy, Removal of Tongue, Avulsion of Gasserian Ganglion (Hartley-Krause).

THIRD DAY.—*Resections, &c.*

Upper Jaw, Lower Jaw, Elbow, Wrist, Hip, Knee, Osteotomy of Femur (Macewen), Exarticulation at Hip.

FOURTH DAY.—*Amputations.*

Foot.—Great Toe, Syme, Subastragaloid.

Leg.

Knee.—Stephen Smith or Stokes-Gritti.

Thigh.

Hand.—Thumb, Wrist.

Fore-arm.

Arm.—Exarticulation at Shoulder.

FIFTH DAY.—*Abdominal Operations, &c.*

Lithotrity, Suprapubic Cystotomy, Removal of Appendix, Inguinal Colotomy, Gastrostomy, Cholecystotomy, Interscapulo-Thoracic Amputation (Berger).

SIXTH DAY.—*Abdominal Operations, &c.*

Enterostomy, Enterectomy and Intestinal Suturing, Gastro-Enterostomy, Application of Murphy's Button, Application of Mayo Robson's or some other form of Bobbin, Lumbar Colotomy, Nephrectomy, Varicocele, Removal of Testicle.

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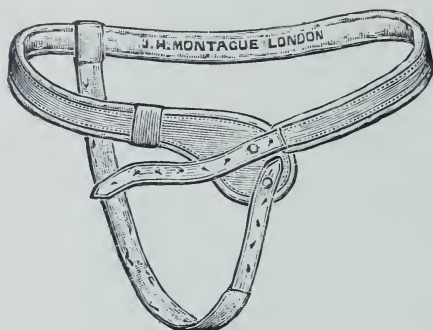
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THIRD DAY.—*Resections, &c.*

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FOURTH DAY.—*Amputations.*

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Knee.—Stephen Smith or Stokes-Gritti.

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Hand.—Thumb, Wrist.

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FIFTH DAY.—*Abdominal Operations, &c.*

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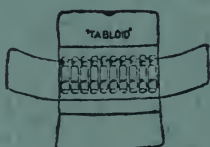
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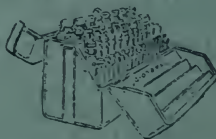
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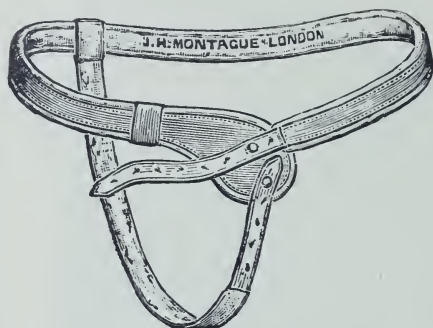
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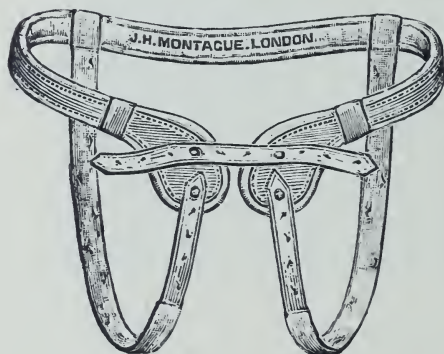
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SCHEDULE OF CLINQUES AND LECTURES

From **APRIL** to **JULY**, 1902.

Cliniques at 4 p.m.

MONDAYS. (<i>Skin</i>)	TUESDAYS. (<i>Medical</i>)	WEDNESDAYS. (<i>Surgical</i>)	THURSDAYS. (<i>Surgical</i>)	FRIDAYS. (<i>Eye, Ear, Nose, and Throat</i>)
			April 3 Mr. Hutchinson	April 4 Dr. Herbert Tilley
April 7 Dr. J. M. H. MacLeod	April 8 Dr. James Taylor	April 9 Mr. J. Hutchinson, Junnr.	April 10 Mr. Hutchinson	April 11 Mr. R. Lake
April 14 Dr. T. Colcott Fox	April 15 Dr. W. Ewart	April 16 Mr. Howard Marsh	April 17 Mr. Hutchinson	April 18 Mr. N. MacLehose
April 21 Dr. A. Whitfield	April 22 Dr. Harry Campbell	April 23 Mr. Jackson Clarke	April 24 Mr. Hutchinson	April 25 Dr. St. Clair Thomson
April 28 Dr. J. Galloway	April 29 Dr. Seymour Taylor	April 30 Mr. J. Berry	May 1 Mr. Hutchinson	May 2 Mr. P. R. W. DeSanti
May 5 Dr. J. F. Payne	May 6 Dr. Theo. Williams	May 7 Mr. J. Hutchinson, Junnr.	May 8 Mr. Hutchinson	May 9 Mr. Marcus Gunn
May 12 Dr. A. Whitfield	May 13 Sir Wm. Broadbent	May 14 Mr. A. H. Tubby	May 15 Mr. Hutchinson	May 16 Dr. Herbert Tilley
May 19 <i>Whit Monday</i>	May 20 Dr. W. Ewart	May 21 Mr. J. Cantlie	May 22 Mr. Hutchinson	May 23 Dr. Dundas Grant
May 26 Dr. J. F. Payne	May 27 Dr. R. L. Bowles	May 28 Mr. A. H. Tubby	May 29 Mr. Hutchinson	May 30 Mr. Ernest Clarke
June 2 Dr. J. J. Pringle	June 3 Dr. James Taylor	June 4 Mr. Jackson Clarke	June 5 Mr. Hutchinson	June 6 Dr. Jobson Horne
June 9 Dr. T. Colcott Fox	June 10 Sir Wm. Broadbent	June 11 Mr. P. J. Freyer	June 12 Mr. Hutchinson	June 13 Mr. R. Lake
June 16 Dr. A. Whitfield	June 17 Dr. C. O. Hawthorne	June 18 Mr. E. W. Roughton	June 19 Mr. Hutchinson	June 20 Mr. Work Dodd
June 23 Dr. J. M. H. MacLeod	June 24 Dr. Guthrie Rankin	June 25	June 26 Coronation Day	June 27
June 30 Dr. J. F. Payne	July 1 Dr. Theo. Williams	July 2 Mr. Reg. Harrison	July 3 Mr. Hutchinson	July 4 Dr. Dundas Grant
July 7 Dr. T. Colcott Fox	July 8 Dr. Seymour Taylor	July 9 Mr. J. Berry	July 10 Mr. Hutchinson	July 11 Mr. Treacher Collins
July 14 Dr. J. Galloway	July 15 Dr. J. E. Squire	July 16 Mr. J. Cantlie	July 17 Mr. Hutchinson	July 18 Dr. St. Clair Thomson
July 21 Dr. E. Graham Little	July 22 Dr. Harry Campbell	July 23 Mr. Johnson Smith	July 24 Mr. Hutchinson	July 25 <i>College closes.</i>

Clinical Lectures at 5.15 p.m.

April 23rd.—F. W. Mott, Esq., M.D., F.R.C.P., F.R.S.

May 7th.—Sir John Batty Tuke, M.P., M.D., F.R.C.P.

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June 18th.—Frederic Eve, Esq., F.R.C.S.

July 2nd.—W. Hale White, Esq., M.D., F.R.C.P.

July 16th.—Sir Anderson Crichtett, M.A.,
F.R.C.S. Ed.

Special Courses of Lectures at 5.15 p.m.

April 18th, 25th, and May 2nd.—Dr. William Hunter, "The Nature and Etiology of Pernicious Anæmia" (with lantern demonstrations).

May 5th and 12th.—Dr. Hugh Playfair, "The Hæmorrhages of Pregnancy."

May 9th, 23rd and 30th.—Dr. Jobson Horne, "Tuberculosis of the Ear, Nose, and Throat."

May 26th, June 2nd and 9th.—Mr. F. C. Wallis, "The Diagnosis and Treatment of Rectal Diseases."

June 6th, 13th and 20th.—Mr. Charles Ryall, "Cancer of the Breast, and its Treatment."

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1902.

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Practical Ophthalmology: the use of the Ophthalmoscope and Refraction	{	L. V. Cargill, F.R.C.S.
Practical Otology	{	J. Dundas Grant, M.D., F.R.C.S. Richd. Lake, F.R.C.S.
Practical Rhinology and Laryngology	{	St. Clair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.D., M.R.C.P.
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 mences April 17. Dr. Harrison Low.
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 Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M.,
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(3) Resections.

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SECOND DAY.—*Head and Neck.*

Trephining Operations.—Middle Meningeal Artery, Lateral Sinus, Mastoid Antrum, Frontal Sinus.

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THIRD DAY.—*Resections, &c.*

Upper Jaw, Lower Jaw, Elbow, Wrist, Hip, Knee, Osteotomy of Femur (Macewen), Exarticulation at Hip.

FOURTH DAY.—*Amputations.*

Foot.—Great Toe, Syme, Subastragaloid.

Leg.

Knee.—Stephen Smith or Stokes-Gritti.

Thigh.

Hand.—Thumb, Wrist.

Fore-arm.

Arm.—Exarticulation at Shoulder.

FIFTH DAY.—*Abdominal Operations, &c.*

Lithotripsy, Suprapubic Cystotomy, Removal of Appendix, Inguinal Colotomy, Gastrostomy, Cholecystotomy, Interseapulo-Thoracic Amputation (Berger).

SIXTH DAY.—*Abdominal Operations, &c.*

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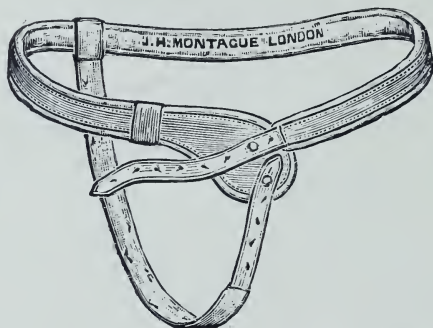
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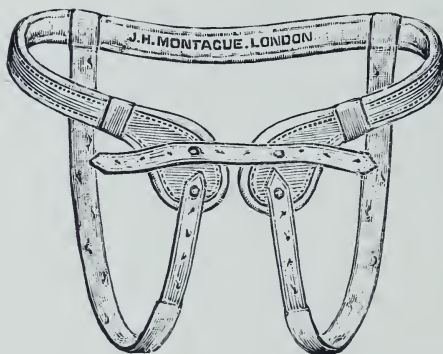
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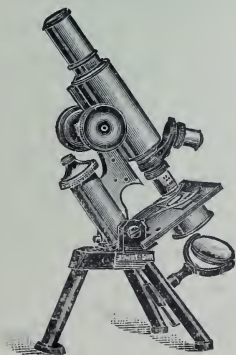
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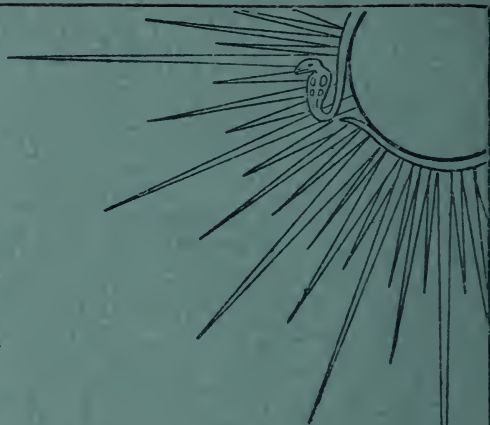
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May 26 Dr. J. F. Payne	May 27 Dr. R. L. Bowles	May 28 Mr. A. H. Tubby	May 29 Mr. Hutchinson	May 30 Mr. Ernest Clarke
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Nerves.—Spinal Accessory, Musculo-spiral, Sciatic.

SECOND DAY.—*Head and Neck.*

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Removal of Eyeball, Oesophagotomy, Laryngectomy, Removal of Tongue, Avulsion of Gasserian Ganglion (Hartley-Krause).

THIRD DAY.—*Resections, &c.*

Upper Jaw, Lower Jaw, Elbow, Wrist, Hip, Knee, Osteotomy of Femur (Maceven), Exarticulation at Hip.

FOURTH DAY.—*Amputations.*

Foot.—Great Toe, Syme, Subastragaloid.

Leg.

Knee.—Stephen Smith or Stokes-Gritti.

Thigh.

Hand.—Thumb, Wrist.

Forearm.

Arm.—Exarticulation at Shoulder.

FIFTH DAY.—*Abdominal Operations, &c.*

Lithotrity, Suprapubic Cystotomy, Removal of Appendix, Inguinal Colotomy, Gastrostomy, Cholecystotomy, Interscapulo-Thoracic Amputation (Berger).

SIXTH DAY.—*Abdominal Operations, &c.*

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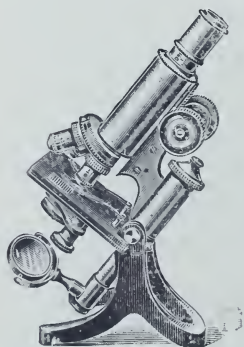
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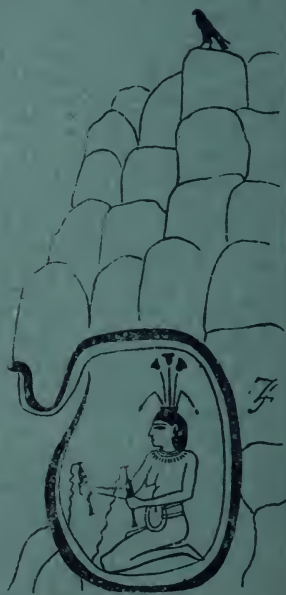
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SCHEDULE OF CLINQUES AND LECTURES

From **SEPTEMBER** to **DECEMBER, 1902.**

Cliniques at 4 p.m.

MONDAYS. (<i>Skin</i>)	TUESDAYS. (<i>Medical</i>)	WEDNESDAYS. (<i>Surgical</i>)	THURSDAYS. (<i>Surgical</i>)	FRIDAYS. (<i>Eye, Ear, Nose, and Throat</i>)
Sept. 8 College opens	Sept. 9 Dr. James Taylor	Sept. 10 Mr. P. J. Freyer	Sept. 11 Mr. Hutchinson	Sept. 12 Dr. Jobson Horne
Sept. 15 Dr. J. Galloway	Sept. 16 Dr. C. O. Hawthorne	Sept. 17 Mr. Reg. Harrison	Sept. 18 Mr. Hutchinson	Sept. 19 Mr. R. Lake
Sept. 22 Dr. A. Whitfield	Sept. 23 Dr. J. E. Squire	Sept. 24 Mr. Jackson Clarke	Sept. 25 Mr. Hutchinson	Sept. 26 Dr. Herbert Tilley
Sept. 29 Dr. Graham Little	Sept. 30 Dr. Harry Campbell	Oct. 1 Mr. James Berry	Oct. 2 Mr. Hutchinson	Oct. 3 Mr. Ernest Clarke
Oct. 6 Dr. J. F. Payne	Oct. 7 Sir Wm. Broadbent	Oct. 8 Mr. J. Cantlie	Oct. 9 Mr. Hutchinson	Oct. 10 Dr. Dundas Grant
Oct. 13 Dr. J. Galloway	Oct. 14 Dr. Seymour Taylor	Oct. 15 Mr. Reg. Harrison	Oct. 16 Mr. Hutchinson	Oct. 17 Dr. St. Clair Thomson
Oct. 20 Dr. A. Whitfield	Oct. 21 Dr. W. Ewart	Oct. 22 Mr. F. C. Wallis	Oct. 23 Mr. Hutchinson	Oct. 24 Mr. Work Dodd
Oct. 27 Dr. J. M. H. MacLeod	Oct. 28 Dr. Theo. Williams	Oct. 29 Mr. J. Berry	Oct. 30 Mr. Hutchinson	Oct. 31 Mr. P. R. W. De Santi
Nov. 3 Dr. J. F. Payne	Nov. 4 Dr. James Taylor	Nov. 5 Mr. J. Hutchinson, Jrnr.	Nov. 6 Mr. Hutchinson	Nov. 7 Dr. Herbert Tilley
Nov. 10 Dr. Graham Little	Nov. 11 Dr. Guthrie Rankin	Nov. 12 Mr. Jackson Clarke	Nov. 13 Mr. Hutchinson	Nov. 14 Mr. Marcus Gunn
Nov. 17 Dr. Colcott Fox	Nov. 18 Sir Wm. Broadbent	Nov. 19 Mr. J. Hutchinson, Jrnr.	Nov. 20 Mr. Hutchinson	Nov. 21 Dr. Dundas Grant
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Dec. 8 Dr. J. Galloway	Dec. 9 Dr. Theo. Williams	Dec. 10 Mr. A. H. Tubby	Dec. 11 Mr. Hutchinson	Dec. 12 Mr. R. Lake
Dec. 15 Dr. J. M. H. MacLeod	Dec. 16 Dr. R. L. Bowles	Dec. 17 Mr. J. Cantlie	Dec. 18 Mr. Hutchinson	Dec. 19 College closes.

Clinical Lectures at 5.15 p.m.

Oct. 15th.—Gilbert Barling, Esq., F.R.C.S., Birmingham.
Oct. 29th.—P. H. Pye-Smith, Esq., M.D., F.R.C.P.
Nov. 12th.—Judson S. Bury, Esq., M.D., F.R.C.P., Manchester.

Nov. 19th.—Peter Horrocks, Esq., M.D., F.R.C.P.
Nov. 26th.—Allan Macfadyen, Esq., M.D., B.Sc.
Dec. 10th.—H. E. Juler, Esq., F.R.C.S.

Special Courses of Lectures at 5.15 p.m.

Oct. 3rd, 10th, and 17th.—Mr. Bellamy Gardner, "The Administration of Anesthetics" (with practical demonstrations).
Oct. 6th, 13th, and 20th.—Dr. G. E. Herman, "Pelvic Inflammations."
Nov. 3rd, 10th, and 17th.—Dr. W. S. Colman, "Infant Feeding, and Ailments due to unsuitable Feeding."

Nov. 7th, 14th, and 21st.—Dr. Louis Sambon, "Parasitism in Man."
Nov. 28th, Dec. 5th, and 12th.—Dr. S. E. Dore, "The Therapeutic Uses of the Röntgen and Finzen Rays" (illustrated by Cases).
Dec. 1st, 8th, and 15th.—Dr. Harry Campbell, "Respiratory Exercises and Thoracic Dynamics."

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Applied Anatomy (Medical and Surgical), Physical Diagnosis	{	Seymour Taylor, M.D., F.R.C.P. J. Edward Squire, M.D., M.R.C.P. James Cantlie, M.B., F.R.C.S. Albert Carless, M.S., F.R.C.S.
Clinical Examination of the Nervous System	{	James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P.
Practical Ophthalmology: the use of the Ophthalmoscope and Refraction	{	L. V. Cargill, F.R.C.S.
Practical Otology	{	J. Dundas Grant, M.D., F.R.C.S. Richd. Lake, F.R.C.S.
Practical Rhinology and Laryngology	{	St. Clair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.D., M.R.C.P.
The Application of the Röntgen Rays		F. Harrison Low, M.B.
Clinical Microscopy		A. E. Hayward Pinch, F.R.C.S.

CLASSES IN ASSOCIATION WITH THE COLLEGE.

Practical Bacteriology	R. Tanner Hewlett, M.D., M.R.C.P.
Mental Diseases	Maurice Craig, M.D., M.R.C.P.
Hygiene and Public Health	A. Wynter Blyth, M.R.C.S., F.C.S.
Operative Surgery	W. Johnson Smith, F.R.C.S.

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Clinical Lectures are given on alternate Wednesdays.

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The routine work of the College will be resumed on Monday, Sept. 8.

TIME-TABLE OF CLASSES OF VACATION SESSION, SEPT. 8 TO 27.

CLASS.	LECTURERS.	MON.	TUES.	WED.	THURS.	FRI.	SAT.	1ST LECT.
Clinical Microscopy	Mr. H. Pinch	2 p.m.	11 a.m.	2 p.m.	11 a.m.	—	—	Mon., Sept. 8
Examination of Nervous System	Dr. H. Campbell	—	2.30 p.m.	—	—	2.30 p.m.	—	Tues., Sept. 9
Röntgen Rays	Dr. H. Low	—	—	—	3 p.m.	—	—	Thurs., Sept. 11
Applied Anatomy	Dr. J. E. Squire Mr. J. Cantlie	—	5 p.m.	—	—	9 a.m.	—	Tues., Sept. 9
Practical Otology	Dr. D. Grant Mr. R. Lake	5 p.m.	9 a.m.	—	—	—	—	Tues., Sept. 9
Practical Laryngology	Dr. W. J. Horne	—	—	5 p.m.	—	—	2.30 p.m.	Wed., Sept. 10
Practical Ophthalmology	Mr. V. Cargill	—	—	—	5 p.m.	5 p.m.	—	Thur., Sept. 11

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(2) Head and Neck.

(3) Resections.

(4) Amputations.

(5) Abdominal Operations, &c.

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Arteries.—Common Carotid, External Carotid, Lingual, Subclavian, Brachial (2), External Iliac, Internal Iliac (Transperitoneal), Femoral (2), Popliteal.

Nerves.—Spinal Accessory, Musculo-spiral, Sciatic.

SECOND DAY.—*Head and Neck.*

Trephining Operations.—Middle Meningeal Artery, Lateral Sinus, Mastoid Antrum, Frontal Sinus.

Removal of Eyeball, Œsophagotomy, Laryngectomy, Removal of Tongue, Avulsion of Gasserian Ganglion (Hartley-Krause).

THIRD DAY.—*Resections, &c.*

Upper Jaw, Lower Jaw, Elbow, Wrist, Hip, Knee, Osteotomy of Femur (Macewen), Exarticulation at Hip.

FOURTH DAY.—*Amputations.*

Foot.—Great Toe, Syme, Subastragaloid.

Leg.

Knee.—Stephen Smith or Stokes-Gritti.

Thigh.

Hand.—Thumb, Wrist.

Forearm.

Arm.—Exarticulation at Shoulder.

FIFTH DAY.—*Abdominal Operations, &c.*

Lithotripsy, Suprapubic Cystotomy, Removal of Appendix, Inguinal Colotomy, Gastrostomy, Cholecystotomy, Interscapulo-Thoracic Amputation (Berger).

SIXTH DAY.—*Abdominal Operations, &c.*

Enterostomy Enterectomy and Intestinal Suturing, Gastro-Enterostomy, Application of Murphy's Button, Application of Mayo Robson's or some other form of Bobbin, Lumbar Colotomy, Nephrectomy, Varicocele, Removal of Testicle.

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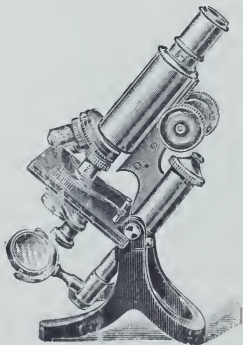
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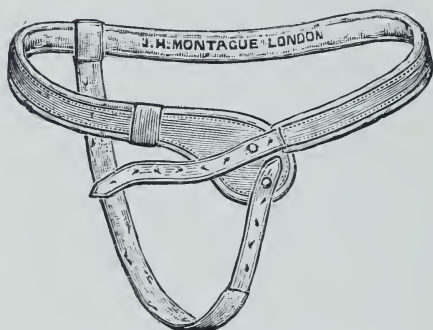
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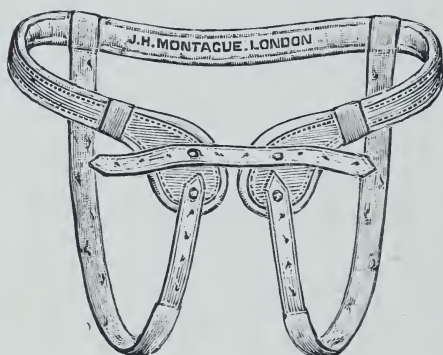
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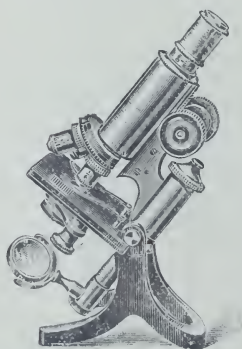
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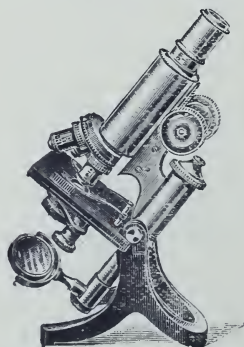
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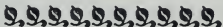


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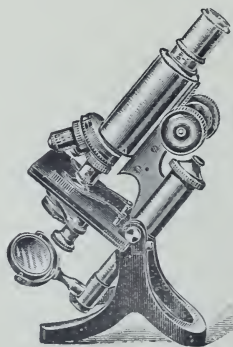
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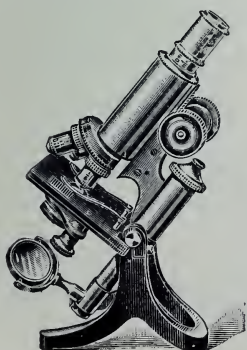
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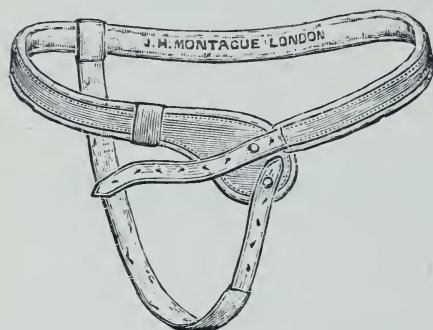
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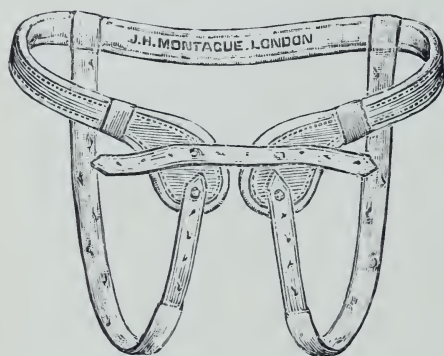
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